EXHIBIT 6

IN THE UNITED STATES BANKRUPTCY COURT

FOR THE DISTRICT OF DELAWARE

In Re:	)
	) Chapter 11
W.R. GRACE & CO., et al,	)
	) Case No. 01-1139 (JKF)
Debtors.	)
	) Volume I

VIDEOTAPED DEPOSITION OF ALAN C. WHITEHOUSE, M.D.

Taken at the instance of the Debtors

March 19, 2009

8:30 a.m.

818 W. Riverside Avenue

Spokane, Washington

BRIDGES REPORTING & LEGAL VIDEO
Certified Shorthand Reporters
1312 N. Monroe Street
Spokane, Washington 99201
(509) 456-0586 - (800) 358-2345

BE IT REMEMBERED that the videotaped deposition of ALAN C. WHITEHOUSE, M.D., was taken in behalf of the Debtors pursuant to the Federal Rules of Civil Procedure before William J. Bridges, Certified Shorthand Reporter for Washington, Idaho and Oregon, on Thursday, the 19th day of March, 2009, at the law offices of Evans, Craven & Lackie, 818 W. Riverside Avenue, Suite 250, Spokane, Washington, commencing at the hour of 8:30 a.m.

* * *

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MORGAN ROHRHOFER

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W.R. GRACE & CO., et al

Case No. 01-1139 (JKF)

March 19, 2009

TESTIMONY

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* * *

THE VIDEOGRAPHER: Good morning. Here begins the deposition of Dr. Alan C. Whitehouse in regarding W.R. Grace & Co. in the United States Bankruptcy Court for the District of Delaware. The case number is 01-1139 (JKF).

Today's date is March 19, 2009. The time is approximately 8:32. The deposition is being taken at Evans, Craven & Lackie, 818 West Riverside, Suite 250, Spokane, Washington.

The videographer is Greg Glover, the court reporter is William Bridges, both here on behalf of Bridges Reporting and Legal Video located at 1312 North Monroe, Spokane, Washington, 99201.

Would counsel and all present please identify yourselves and state whom you represent.

MR. STANSBURY: Brian Stansbury of Kirkland & Ellis, and I represent W.R. Grace & Company.

MR. HEBERLING: Jon Heberling of McGarvey, Heberling, Sullivan & McGarvey, representing the Libby claimants.

MR. SCHIAVONI: Good morning, Doctor. Tancred Schiaoni from O'Melveny & Myers. I represent Arrow Wood.

MS. LEE: Karen Lee, Kirkland & Ellis, representing W.R. Grace.

MR. STANSBURY: People on the phone, could you introduce yourselves please, again, for the benefit of the court reporter.

MS. STOVER: Laura Stover, Eckert Seamans, Cherin & Mellot, representing Maryland Casualty Company and Zurich American Insurance Company.

MR. BAILOR: Bernard Bailor from Caplin & Drysdale, Washington, D.C., representing the Asbestos Claimants Committee.

MR. GUY: Jonathan Guy, Orrick, Herrington & Sutcliffe, representing the Future Claimants Representatives for P.I. claims.

MR. BLABEY: David Blabey, Kramer, Levin, Naftalis & Frankel, representing the Equity Committee.

MS. DeCRISTOFARO: Elizabeth DeCristofaro, Ford, Marrin, Esposito, Witmeyer & Gleser, for Continental Casualty Company.

THE VIDEOGRAPHER: Would the court reporter please swear in the witness.

(ALAN C. WHITEHOUSE, called as a witness by the Debtors, being first duly sworn to tell the truth, the whole truth and nothing but the truth, was examined and testified as follows:)

EXAMINATION

BY MR. STANSBURY:

Q. Good morning, sir.

A. Good morning.

Q. Could you please state your name for the record?

A. Alan Whitehouse.

Q. And you are a medical doctor, right?

A. I am.

Q. Dr. Whitehouse, my name is Brian Stansbury. I represent W.R. Grace.

Before we get started, I wanted to go over a few background issues just to make sure we were on the same page. I know this isn't your first time at the rodeo. But I wanted to ask you a few questions.

First of all, I'm going to assume you understand my question, unless you say otherwise.

Is that fair?

A. That's fair. I have some hearing problems, though.

Q. Okay. Please let me know if at any time I'm talking too fast or you do not understand my question. Okay?

A. Okay.

Q. Additionally, I will ask that when I am asking a question, that you will allow me to finish the question before answering, and I will strive to do the same when you are answering the questions. That way the court reporter keeps the record clear.

Does that sound good?

A. Okay.

Q. Additionally, when answering questions, I will ask that you answer with an audible yes or no, as opposed to a nod, just, again, so the record is clear.

Is that fair?

A. Yes.

Q. Are you under any medication today that would affect your ability to answer questions?

A. I don't think so.

Q. Okay. All right. Dr. Whitehouse, I'm handing you what's been marked as Exhibit 1. And this is a deposition notice for today.

And you are Dr. Alan C. Whitehouse, correct?

A. That's correct.

Q. Okay. And you intend to offer expert testimony in the matter of In re: W.R. Grace & Company, correct?

A. I do.

Q. Okay. And it is March 19th, 2009, correct?

A. Yes.

Q. Okay. Now, I'm going to hand you what's been marked as Exhibit 2. And this document is entitled Libby Claimants' Preliminary Objections to First Amended Joint Chapter 11 Plan.

Have you ever seen this document before?

(Pause in the proceedings).

A. I have not seen this specific document. I am familiar with what's in it, though.

Q. All right.

A. But I am reading it right now.

Q. All right. The reason I present this to you is it is my understanding that the Libby claimants are objecting to the proponents' plan.

And on page 2 there's a list of criticisms. And I think you may have opinions with respect to some of them. And I wanted to ensure that you do or do not.

The first, and I'll read, and tell me if I am reading this correctly, "The TDP excludes legitimate Libby claims by requiring the blunting of the costophrenic angle as a criterion for disease level."

Do you see that?

A. Yes.

Q. Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. I do.

Q. Okay. Next statement. "The TDP excludes legitimate Libby claims by requiring a minimum three millimeter pleural thickening as a criterion for disease level."

Do you see that statement?

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. Okay. Next, "The TDP excludes legitimate Libby claims by requiring pleural thickening coverage of over 25 percent as a criterion for disease level."

Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. I do.

Q. Next, "The TDP excludes legitimate Libby claims by not permitting the use of DLCO to establish severity and impairment of asbestos-related disease."

Did I read that correctly?

A. Yes.

Q. Do you agree with that statement?

A. I do.

Q. Next, "The TDP excludes legitimate Libby

claims by requiring an FEV1/FVC ratio over 65 percent as a criterion for disease level."

Did I read that correctly?

A. Yes.

Q. And do you agree with that statement?

A. I do.

Q. Now, you intend to offer opinions at a hearing related to the disease that various Libby claimants have, is that correct?

A. That's correct.

Q. And based on these statements, it is your belief that the current mechanism for assessing claims does not properly characterize Libby disease?

Is that true?

MR. HEBERLING: Objection. Calls for a legal conclusion.

THE WITNESS: Basically -- Repeat the question again.

MR. STANSBURY: Would you read back the last question, please sir.

(Record read).

THE WITNESS: I agree.

Q. (BY MR. STANSBURY:) And just so I am clear, when we are talking about disease and Libby, are we talking primarily about the interstitial disease in Libby

or the pleural disease in Libby?

A. We are talking about everything, but predominantly the pleural disease.

Q. So, your objection is really to the way we are dealing with pleural disease, is that correct?

A. Not entirely.

Q. Primarily?

A. Primarily.

Q. And do you believe that the pleural disease suffered by people in Libby exposed to tremolite from Libby is distinct from pleural disease other people exposed to other asbestos may have?

A. Well, to begin with, your statement is incorrect, because it's not tremolite that we are talking about. We are talking about winchite, richterite and tiny amounts of tremolite.

So, we're talking about a different category of asbestos, in part.

Q. And so I am clear, that that mixture of minerals has been referred to in the past as the Libby amphibole, is that correct?

A. That's correct.

Q. Okay. So, with that caveat, is it your belief that people who have been exposed to this winchite, richterite, tremolite hybrid are -- have a

pleural disease that is distinct from individuals who have been exposed to other forms of asbestos?

A. "Distinct" is a difficult word to use in that situation.

There are manifestations of it that are frequently different. They are much more severe in general. Any of these findings may be seen in other types of asbestos. It is just the degree. We have to clarify what we are talking about.

Q. All right. Well, let's clarify what we are talking about, just so we are clear. Do you believe that people who have been exposed to winchite, richterite, tremolite from Libby have a more severe form of pleural disease than people exposed to, let's say, chrysotile?

A. Yes. Clearly.

Q. Okay. Do you believe that people exposed to winchite, richterite, tremolite from Libby have a more severe pleural disease than people exposed to amosite?

A. That's not been totally established, because there's -- You might want to use the term amphiboles. Okay?

Q. Okay. Let me back up, just so that I am clear.

A. Why don't you back it up, put it into a

category that works.

Q. Sure. Sure. So, on the -- and maybe this is important, then. So, perhaps it's not winchite, richterite, tremolite that it creating the more severe pleural disease, it is all amphiboles in general, is that correct?

A. There's two parts -- There's more than one part of the answer to that.

One is that all amphiboles seem to have more pleural disease, and that's true from the Australian studies and other studies.

But in addition, it would appear as if Libby asbestos, and this is somewhat preliminary, is worse than amosite, not yet established whether it's worse than Australian crocidolite. It may very well be.

Q. All right. So, you've said a lot there, and let's unpack that.

Chrysotile you firmly believe does not cause the same severe pleural disease that winchite, richterite, tremolite does, correct?

A. Yes.

Q. Okay. And as you just said, amosite likely does not cause as severe pleural disease as winchite, richterite, tremolite do, is that correct?

A. When you look at the studies of, like,

insulators, they were exposed to both chrysotile and amosite, because that was the mixture that was in most of the asbestos on the East Coast.

So, how you distinguish those two clearly, one from the other, is difficult to do, because you can't do both exposures at the same time.

To my knowledge, there are a few studies relative to amosite alone. I'm not really very familiar with those.

Q. Okay. So, you're more familiar, then, with studies involving chrysotile, crocidolite, and I believe you mentioned --

A. Uh-huh.

Q. -- the experience with it when you were in Australia?

A. Yes.

Q. And those are studies authored be Cookson, is that correct?

A. And others.

Q. And others. But Cookson has written studies about -- -

A. Cookson, and other people.

Q. So, you don't necessarily have an opinion at this time as to how pleural disease from exposure to winchite, richterite, tremolite, compares to amosite,

correct?

A. Pure amosite?

Q. Pure amosite. Correct.

A. The amosite that's related to chrysotile, I had a fair amount of experience. But there is amosite in the chrysotile that most of the insulators were exposed to.

Q. And, so, those people who were exposed to this mixture of chrysotile and amosite, they do not have the same severe pleural disease that people who were exposed to winchite, richterite and tremolite?

A. No. They have very different characteristics of their disease and death rates and things like that.

Q. All right. So, the chrysotile, amosite exposures are different from the winchite, richterite tremolite exposures, correct?

A. I believe it is.

Q. With respect to pleural disease, correct?

A. With respect to the extent of pleural disease and probably the potency. But some of that, I think based upon known exposure levels of the insulators, yes, it is very different.

Q. Okay. I understand. But with respect to crocidolite, crocidolite exposures may cause pleural

disease that is as severe as the pleural disease caused by exposure to winchite, richterite and tremolite, is that right?

A. I suspect it is.

Q. Okay. Now, let's talk about your basis for that.

May I ask you what you have in front of you, sir?

A. My exert report.

Q. Okay. Could I see a copy of that, please?

A. And Arthur Frank's is in there, too.

Q. Okay. I'm going to mark this as an exhibit. And this is the expert report of Dr. --

A. Are you planning to take that with you?

Q. Well, we will copy it and you can keep the original.

A. You've already got a copy.

Q. No. I understand. But we are going to have a file copy for the court reporter.

So, this is a binder that contains CD's, and the CD's listed are 123 patients for Whitehouse 2004; Libby studies as of 12/08; Whitehouse References, 12/08; Whitehouse Progression Films, Exhibit 6; Mortality Study, Medical Records, 116, Exhibit 7; Mortality Study, Death Certificates, 85, Exhibit 7; Mortality Study,

Spreadsheets, Exhibit 7; Libby Mesos, Exhibit 9; Weill Comparison, Exhibit 19; CARD PFT Comparison, Exhibit 23.

Are there any other CD's in this binder other than those that I have just listed?

A. No, not that I know of.

Q. And is this your complete expert report?

A. Yeah.

Q. Okay. Do you intend to offer any opinions at this hearing that are not contained in this report?

MR. HEBERLING: Brian, we have issued a supplemental expert report at this point.

MR. STANSBURY: The one that was served --

MR. HEBERLING: Rebuttal opinions and so forth.

MR. STANSBURY: Okay.

Q. So, other than rebuttal opinions, do you intend to offer any other opinions?

A. It depends on what you ask me.

Q. Okay.

A. If you ask me things that are out of that scope, and I could answer them, then I will.

Q. Okay. Now, let me ask you this, then: With respect to your opinions regarding Libby pleural disease --

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First of all, other than the characterization of Libby pleural disease, is there any other aspect of the Grace medical criteria that you have examined that you find objectionable?
A. Yes.
Q. What is that?
A. Oh, some of the references -- I don't know if these are actually written in the entire scope of it, but objections to obstructive disease as relates to asbestosis.
Q. Okay.
A. Objections relative to smoking. Other diseases. There's a whole host of things --
Q. Let's --
A. -- that don't make sense medically.
Q. Let's flush this out, just so we are clear. First, as we were discussing, pleural disease.
A. Right.
Q. And you believe that the plan as proposed does not properly compensate people who have been exposed to winchite, richterite and tremolite, correct?
MR. HEBERLING: Objection. Calls for a legal conclusion. Ask him about the medical criteria.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, you can answer the question.

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A. Repeat the question.
Q. You believe that the Grace plan adequately compensates people for pleural disease who were exposed to winchite, richterite and tremolite?
A. No, clearly --
MR. STANSBURY: Objection. It calls for legal conclusion.
THE WITNESS: From my standpoint, it clearly does not adequately compensate them.
Q. (BY MR. STANSBURY:) Because of the medical criteria?
A. Because the medical criteria are very flawed.
Q. Let's make a list of those medical criteria right now. What are the criteria that you find problematic with respect with pleural disease?
MR. HEBERLING: Objection, overbroad. He doesn't have the criteria in front of him.
THE WITNESS: That is true. And I might forget one. But I will --
First off, the ones that are listed here.
Q. (BY MR. STANSBURY:) Okay. The ones we just listed?
A. Yeah. Related to thickness of blunted angles, extent --
Q. So, let me see.

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A. So, the FEV1/FVC ratio and the DLCO, those to begin with are the more obvious. There are a whole bunch of other ones.
Q. All right. So let's list those. With respect to the definition of diffuse pleural thickening, or DPT, is it often called that?
A. Yes.
Q. Okay. You object to requiring blunting of the costophrenic angle, correct?
A. Yes.
Q. And what is the costophrenic angle?
A. That's the angle of the lowest part of the lung laterally, inferiorly, where the diaphragm meets the chest wall.
Q. Okay. You also object to the requirement that the pleural fibrosis cover 25 percent of the pleura, is that correct?
A. Yes.
Q. You also object to the requirement of a three millimeter thickness, is that correct?
A. Yes.
Q. What else do you object to with respect to the definition of diffuse pleural thickening?
MR. HEBERLING: Objection, unfair question. He does not have the definition in front of

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him.
THE WITNESS: Actually, I think it would be a good idea if you would give me the definitions, the whole plan, so I don't have -- I have most of them in my head, but I want to make sure I don't miss something.
Q. (BY MR. STANSBURY:) I don't believe I have the entire list with me right now.
If we could just kind of go through the medical side, in terms of what medical criteria you think are flawed, and to the extent that we locate the list, we can circle back, if necessary. So far we have listed blunting of the costophrenic angle, the requirement that it cover 25 percent of the pleura, the three millimeter thickness requirement.
A. Uh-huh.
Q. What else do you find objectionable with respect to the definition of diffuse pleural thickening?
A. The FEV1 --
MR. HEBERLING: Objection, overbroad, unfair question. He doesn't have the criteria in front of him.
Q. (BY MR. STANSBURY:) You said --
A. FEV1/FVC ratios.
Q. Now, is that with respect to the definition of diffuse pleural thickening, or is that more of an

impairment issue?
A. Well, it's an impairment issue, but it is all part of the same package.
Q. Okay. So, to the extent that they require showing a restricted defect to recover for diffuse pleural thickening --
A. Yeah. They require showing a restrictive defect, where it's been shown that the obstructive defect is more common.
Q. Okay.
A. And they just leave that out. They just choose to ignore that.
Q. And the FEV1/FVC ratio is a method of determining whether a defect is restrictive or obstructive, correct?
A. Well, it is and it isn't. The problem is, that this is not that simple. And you can put something like that in legal terms and write all of these numbers down and everything else, and you will find out that half the patients already fall out of it, because it's a thing that's very much judgment issues, it's based on all kinds of criteria, rather than just a single set of written down --
Q. Well, let's unpack the FEV1/FVC ratio. The FEV1 measures the amount of air exhaled in the first

second of a spirometry test, correct?
A. Correct.
Q. And the FVC is the force vital capacity, correct?
A. That's correct.
Q. That is the entire level of air that's exhaled, is that correct?
A. That's the volume that's exhaled, yes. That's the volume from maximal inspiration to maximal expiration.
Q. And so, this ratio compares the amount of air exhaled in the first second with the total volume of the air that is exhaled, correct?
A. That's correct.
Q. And just so I'm clear, the notion of the FEV1/FVC ratio, the reason it's instructive to a pulmonologist is that it determines what level of air is getting out in the first second compared to the amount of air exhaled total, correct?
A. That's correct.
Q. And if there's an obstructive defect, it might take a person a little while to exhale, as opposed to somebody who does not have an obstructive defect, is that correct?
A. That's true.

Q. Okay. And so, somebody who has a lower FEV1/FVC ratio is not exhaling as much in the first second as he or she is throughout the total test, correct?
A. No. But don't try to equate that necessarily to obstructive disease by itself.
Q. But is that true, though?
A. That's true.
Q. Okay. And there are people in your profession who use that measurement to assess whether there is an obstructive component to observed impairment, correct?
A. That's correct.
Q. Okay. So, it is not -- the FEV1/FVC ratio is not some far-out concept that you've never used, correct?
A. No.
Q. Okay.
A. Use it all the time.
Q. Right. And in your practice, if you see somebody who has an FEV1/FVC ratio of 35, let's say, would that suggest that they may have an obstructive defect?
A. Now, you are talking about the extreme levels of that. When you are talking about 65 percent, people over the age of 70, their normal predicted FEV1/FVC ratio

is very close to that.
Q. Okay.
A. And, so, you've allowed virtually zero margin beyond that point.
Q. Now, this objection with respect to the application of the FEV1/FVC ratio, is that something that you think is specific to people who have been exposed to winchite, richterite, and tremolite, or would you say this is a criticism you have with respect to the application of this ratio generally across all claimants?
A. Basically, I consider it generally across all the asbestos. It is possible in any patient with asbestos disease.
Q. All right. So, you do not think that somebody who is exposed to chrysotile should be treated differently from somebody who has been exposed to winchite, richterite or tremolite with respect to the FEV1/FVC ratio, correct?
A. That's not able to be answered as a yes or no.
Q. Well, why not?
A. Why not? Because of the fact that you've got so many other factors that go into this. You haven't mentioned the things that are really important, is, is there a combined restrictive defect, is there an elevated

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residual volume, what's the total lung capacity. These things don't occur in absentia.
Q. Okay.
A. When you do pulmonary function studies, you don't look at one single number. You look at the whole study as it relates to age. And then in addition to this, you've got a whole bunch of different authors for normal predicted numbers.
Q. All right.
A. So, you have to define who you are going to use. I think there's at least 11, to my latest knowledge, and it keeps changing. So, how are you going to define whose you are going to use?
Q. Okay. I understand that. But just so I am clear, everything you've said just now, you would make that same argument if you were talking about somebody who had been exposed to chrysotile as you would somebody who had been exposed to winchite, richterite, tremolite, correct?
A. I might, that particular argument, yes.
Q. All right. With respect to the diffuse pleural thickening we were speaking of earlier, that's an issue that is more specific to the people that have been exposed to the winchite, richterite, tremolite amphibole, correct?

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A. Clearly more, because of the extent of the pleural disease --
Q. All right.
A. -- in that group.
Q. I just wanted to make sure we were clear on that. So, the definition of the diffuse pleural thickening, that is something that is much more of a Libby-specific issue, correct?
A. I think generally related to the fact that we have so much pleural disease there, which is not seen nearly to that extent with chrysotile.
Q. Okay. FEV1/FVC issue. We have discussed this. Now, you disagree with the use of this metric, so to speak. Is that the right way, metric?
A. No.
Q. You would disagree with the use of that lung function measurement as the way --
A. No. We use that measurement. I disagree with putting an absolute number on it in absentia of other aspects of it.
Q. Okay. And that objection you just made is universal across anybody exposed to asbestos?
A. Yes.
Q. It is not Libby-specific?
A. Any competent chest physician is going to

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make that objection.
Q. So is not Libby specific. Let's talk about DLCO. What is DLCO?
A. Diffusion capacity for carbon monoxide in milliliters per minute, per millimeter mercury barometric pressure.
Q. And earlier that was among -- I think that was the fourth list on Exhibit -- fourth item on the list in Exhibit 2, was the "TDP excludes legitimate Libby claims by not permitting the use of DLCO to establish severity impairment of asbestos-related disease."
Correct?
A. That's correct.
Q. And you feel very strongly about this, correct?
A. Oh, yeah. Very strong about it.
Q. You think that if somebody has a decrement in DLCO, that that could be attributed to their asbestos disease, correct?
A. Yes.
Q. Now, so, you would suggest using DLCO as one measurement to determine whether somebody has an asbestos-related disease, and more specifically, impairment associated with that disease, correct?
A. Yes.

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Q. Do you believe that DLCO is a more specific -- Strike that.
Do you believe that DLCO is a more effective lung function measurement for assessing lung disease in Libby, amongst people exposed to winchite, richterite and tremolite, as opposed to people exposed to chrysotile?
A. There is no one measurement. There are a number of problems associated with that.
We know the reason for why the DLCO's are decreased. Okay? They are due to subpleural fibrosis and they're frequently not present on the plain chest films.
You can see lots of stuff in the literature concerning DLCO decreases in pleural disease alone, and some of those articles relate to chrysotile. There's not a huge number of articles on that. But DLCO has been known to be reduced for years, and people for God knows what reason have chosen to ignore it.
Q. Now, the fact that DLCO can be used to assess impairment amongst people exposed to asbestos, you believe that people exposed to winchite, richterite and tremolite are more likely to have a decrement in DLCO than somebody who was exposed to chrysotile?
A. Yeah. I think so.
Q. Okay. So, DLCO, the use of DLCO to determine

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whether there is impairment, that is especially important when assessing somebody exposed to winchite, richterite and tremolite, correct?

A. Oh, I'm not saying it's especially important. All of these things are important, taken in their context.

You're trying to make one single thing more important, this more important, this more important. That's now how it's looked at.

Q. Well, let's look at it --

A. That's not how it should be looked at.

Q. All right.

A. Physicians don't look at it that way. Remember, I'm a practicing physician. I am not an academician up there making rules for the world. Okay?

Q. Understood.

A. I'm looking at real people and their real problems and their pulmonary function abnormalities.

Q. And one of the reasons we want to use DLCO in your opinion is we do not want to overlook somebody who has impairment, correct?

A. No. Absolutely. In fact, we have people that are on continuous oxygen with low DLCO's in normal spirometry and normal lung volumes, and that's their only isolated abnormality.

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Q. Okay.

A. And we have the radiographic evidence to back it up --

Q. So, we have --

A. -- on top of it.

Q. So, we have people who have normal FVC and normal TLC, but reduced DLCO, correct?

A. Yes.

Q. And people who, you say, have radiographic evidence of pleural disease, correct?

A. Yeah, on CT-scan generally.

Q. On CT-scan. What about x-ray?

A. You don't see the interstitial stuff on the x-rays. You see, it is the interstitial stuff that gives you the low DLCO, not the pleural disease by itself.

Q. Okay. Well, let's back up a second. That's important.

My understanding was we were talking about diffuse pleural thickening earlier --

A. Uh-huh.

Q. -- and how to define it, correct?

A. Uh-huh.

Q. Could you answer yes or no, sir?

A. Yes.

Q. Okay. Now, does diffuse pleural thickening

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in the absence of interstitial disease cause a decrement in DLCO?

A. That's a very interesting question, and one that I actually would really like to answer.

My suspicions are, based upon looking at hundreds of CT-scans with diffuse pleural thickening, is that the DLCO decreases are usually associated with subpleural interstitial disease right adjacent to the areas of fibrosis.

You can't see it on the plane chest x-ray. It varies in degree. And even on CT it is not a perfect test.

So, you see pleural thickening and a low DLCO. Interstitial disease is probably there, but you may not see it. It depends on the technique. It depends on the quality of the equipment. There's a myriad of factors that go into it.

Q. So, we just might not be able to see it.

A. You may not be able to see it at that point. Or you may see minimal degrees of it. And it may be a lot more than that.

Most of the time we see it.

Q. Do you think you are more adept at recognizing this, as you call it, subpleural fibrosis, than a different physician would be?

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A. No, not necessarily. I think the other two physicians that work up in the CARD clinic, Dr. Black, and Dr. Heppe, both recognize that just as well as I do.

I would dare say, though, that there are a limited number of people in this country that really understand the significance of that, and those are the people that work, and generally are pulmonologists who work all the time with people with asbestos disease.

Q. What is Dr. Heppe's first name?

A. Mark.

Q. Mark. And what is his background?

A. He's an internist.

Q. What is an internist?

A. That's a physician that practices general internal medicine. He's done that for years. He's very experienced. And he's been at the clinic for a couple of years. And he's also been seeing this stuff for years in the emergency room at the hospital.

Q. Did he do a residency in pulmonology?

A. No.

Q. Did he do a residency in radiology?

A. No.

Q. Did he do a residency in occupational medicine?

A. No.

Q. Did he do a fellowship in radiology?
A. No. All of these questions are going to be no, and you know it, even before you ask me.
Q. Well, I just want to make sure, just so he have this understanding.
A. Well, you're making the assumption that because you had all of this particular training, that you can't see things, you know.
Competent physicians with an open mind who are inquisitive see these things. And they understand. And it doesn't take them very long. They read the literature. And we have a wealth of literature up there available to us. And they get it.
Q. So, Dr. Heppe has not completed a residency or fellowship in radiology, pulmonology or occupational medicine, correct?
A. No.
Q. Okay. The other physician is Dr. Brad Black, is that correct?
A. That's correct.
Q. And Dr. Brad Black has not completed a residency or a fellowship in radiology, pulmonology or occupational medicine, correct?
A. That's correct.
Q. His primary training is a pediatrician,

correct?
A. Originally, yes.
Q. Okay. But correct, yes?
A. Yes. That's correct.
Q. Okay. And asbestos disease is not very common in children, is it?
A. I'm not so sure about that anymore. But probably not.
Q. When they --
A. We're going to find that out in about 10 years.
Q. We're going to find that out in 10 years. Why is that?
A. Because we've got a ton of children that have been exposed to this stuff.
Q. When? Do you know?
A. All along here.
Q. All along?
A. But particularly, all along from, regardless of when they were born. But in the last 10, 20 years, as well.
Q. Currently, ongoing?
A. Probably. But I don't know the extent of it now.
Q. Do you know anything about the levels of

exposure?
A. I do in the past, but I don't know now.
Q. Do you know about the levels of past community exposures?
A. Yes, I do.
Q. And what were the highest levels?
A. Well, the levels at the hospital in downtown and around the mill were about, as I recall the highest I saw was a little bit over 1.5 fiber per cc.
Q. Fiber per cubic centimeter, is that correct?
A. That's correct.
Q. And when was that measurement taken?
A. Late '70s.
Q. Late '70s?
A. Or early '80s.
Q. Or early '80s.
A. I think it was the late '70s.
Q. Late '70s. Well, let's say 1980, to be conservative. So, somebody who had been exposed at the age of one to that measurement in 1980 --
A. Uh-huh.
Q. -- would be 30 years old now?
A. Close to it, yeah.
Q. Okay. Do you have any specific measurements post-1980 regarding community exposure?

A. No. I know there are some, but I don't have them. I haven't seen them.
Q. So, you sitting here, you can't offer an opinion about the levels of exposure, correct?
A. No. You know, we went through in the criminal trial about all of this, you know.
Q. Right.
A. What is, is.
Q. What is, is.
A. What is, is. If you have the disease, you were exposed -- and you lived in Libby, you did get the exposure.
Q. If you have which disease?
MR. HEBERLING: Objection. Please let him finish. That was one of the agreements at the beginning.
THE WITNESS: If you were exposed to -- If you have asbestos changes in your radiograph and you have -- you lived in Libby, you were exposed to asbestos.
Now, you have to do a good exposure history. But you may not be able to find out exactly which exposure was the worst, whether it was the track, piles of stuff that were left around somebody's attic, whatever. I mean, this stuff is still in attics all over Libby.

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So, if you show up with asbestos disease, I don't really care what the exposure levels were. It doesn't matter. It was enough to give them disease.
Q. (BY MR. STANSBURY:) And by "disease," you mean interstitial fibrosis, for example?
A. No. I mean any asbestos things.
Q. But --
A. This is all a spectrum, all the way from a plaque to interstitial disease. And you've seen it already. You saw it on the board in Judge Molloy's courtroom. You saw x-rays that went from a plaque to interstitial disease. You now have two of them on CD that you can look at. They're the same thing. And I've got dozens more, if necessary, probably.
Q. This is interesting. But I want to kind of close out what we were first talking about real quick before we move on to --
A. I think I just closed it off. Okay?
Q. DLCO, this discussion began as we were talking about, whether it was caused by the diffuse pleural thickening --
A. Uh-huh.
Q. -- or, as you call it, subpleural interstitial fibrosis.
A. Subpleural fibrosis is what we refer to it

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as.
Q. Subpleural fibrosis, correct?
A. Yes.
Q. Okay. And it is your belief that it is not the pleural fibrosis but the subpleural fibrosis, and that would be fibrotic changes within the lung itself, correct?
A. Yes. Although, you know, you have to consider other things that go along with this. Many times there's lung entrapped in pleural thickening.
And, so, that may be a shunt for oxygen uptake, and that may order the DLCO in itself.
And, so, it is possible, even though you don't see interstitial fibrosis, that there's enough alteration in the ventilation profusion ratios in that area right around the pleura that it would affect the DLCO.
Q. So, that would be an example where a pleural fibrotic change in and of itself could affect DLCO?
A. I think it's possible. I think more often than not, though, we see subpleural fibrosis.
Q. More often than not it's subpleural fibrosis?
A. I think for the most part, yeah.
Q. So, that's fibrotic changes within the interstitium, correct?

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A. Right in the subpleural region, yes.
Q. But it would be within the interstitium, the actual lung itself?
A. Yes.
Q. So, that would be interstitial fibrosis, correct?
A. I guess, if you want to call it that way. Although we don't quite use that term. Because you get all of these definitions in the past that have evolved around plain chest x-rays.
Now we are talking about CT's. We're not talking about chest x-rays. This is stuff that we are not seeing on chest x-ray. We are seeing only on the high resolution CT's.
Q. So, you --
A. And actually we are only seeing it since we really got an upgrade in the last three years or so.
Q. And the "we" would be you, Dr. Heppe and Dr. Black?
A. And Dr. Becker.
Q. And Dr. Becker.
A. And a couple radiologists in Kalispell also.
Q. And what are their names?
A. Oh -- Well, there's McDonald. I don't remember the other names.

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Q. Okay. So, Dr. Becker can --
A. And Gordon Teel, also, of course, who I've worked with for years.
Q. Gordon Teel.
A. Although I haven't been working with him more recently. He's well aware of this, also.
Q. What about Dr. Lynch at National Newish? He can see this, correct?
A. Correct. And Dr. Newell who also looks at these as well.
Q. What about Dr. Shipley at Cincinnati?
A. I think Dr. Shipley is incompetent when it comes to looking at these -- at the Libby asbestos pleural disease.
Q. Shipley is incompetent with respect to the Libby asbestos pleural disease?
A. I believe that, yes. Because I think that -- And all of us have felt that same way about it.
Q. Okay. What about Dr. Molina at North Carolina?
A. He's very spotty. I mean, these are the two guys that Grace's insurance plan sends all of the x-rays to. And Molina is sort of on and off. Sometimes he sees things, sometimes he doesn't.
Q. So, he's not incompetent, he's on and off, is

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that correct?
A. Yeah.
Q. What about Dr. Pistorese, and I'll help you with the spelling, I believe it's P-I-S-T-O-R-E-S-E, in Kalispell?
A. You know, you're asking me to make statements about physicians who are actively in private practice. And I'm not going to do that. Okay? I don't mind talking about Shipley.
But I'm not going to make comments like that in a public purview concerning physicians who are sometimes doing what they think are right, but with whom many of us disagree.
And, so, I'm not willing to say anything other than the fact that we frequently disagree with him.
Q. Okay. Well, I'm not asking you to use the word incompetent. That was your word with respect to Dr. Shipley.
A. I know it was. That's right.
Q. With respect to Dr. Pistorese, and this is not a pejorative inquiry, but simply a question as to whether Dr. Pistorese recognizes this subpleural fibrotic change that you were discussing --
A. I don't --
Q. If I could finish.

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-- that causes the decrement in DLCO.
A. I have no idea, because I don't know that he's even seen any of these. He hasn't seen any of the Libby patients for a number of years. For whatever reason, we have not seen his name on things for a long time.
Q. What about Dr. Obermiller, also in Kalispell? Same question.
A. I don't know whether he does or not.
Q. So, you do not know whether he is capable of recognizing this subpleural change that --
A. Oh, I am sure he is capable of it.
Q. Let me just finish.
A. All right.
Q. You do not know whether Dr. Obermiller recognizes this subpleural change that causes the decrement in DLCO?
A. I think he probably does. But I can't give you a specific example. I don't -- I haven't seen very much from him either recently.
Q. Okay.
A. Although I must admit he almost tends to disagree with everything that's done in the CARD Clinic all the time.
Q. Okay. Now, just to kind of wrap up the DLCO

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point for now.
A. Uh-huh.
Q. It is, in your opinion, the decrement in DLCO can be caused either by fibrotic changes of the pleura, or subpleural interstitial changes that you often recognize on CT but not on x-ray --
A. Yes.
Q. -- that occur in connection with the diffuse pleural thickening, is that correct?
A. Yes. And there are other causes for a decreased DLCO that we haven't gotten into, though.
Q. Non-asbestos-related causes, or asbestos-related causes?
A. Non-asbestos-related causes. But they coexist.
Q. Okay. So, there are certainly other causes in decrement in DLCO that have nothing to do with asbestos?
A. Yes. That's right.
Q. Such as smoking? Correct?
A. Well, assuming that you have -- Usually that occurs with very severe obstructive airway disease in the absence of any asbestos disease, yeah.
Q. What else can cause a decrement in DLCO?
A. All kinds of other interstitial lung

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diseases. I mean, there's only about, I think there's probably 500 or so listed in causes of interstitial lung disease.
Q. So, there's potentially 500 different causes of a decrement in DLCO?
A. Who knows? I don't know what the actual number is. It may not be that many. But there's a very large number of interstitial lung diseases, all of which are capable of producing a decrease in DLCO.
Q. So, certainly a decrement in DLCO is not dispositive for the presence of an asbestos-related disease, correct?
A. Well, not by itself, no.
Q. And this phenomena that we've discussed earlier with respect to either the pleural change or the subpleural interstitial change causing the decrement in DLCO, is that a specific finding with respect to those exposed to winchite, richterite and tremolite, or is that a general finding for people exposed to chrysotile asbestos, as well?
A. I can't answer your question, because I have not looked at large numbers of high resolution CT-scans on people that are just solely chrysotile exposed.
Q. Do you believe that people who have chrysotile exposures -- Let me start that over.

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Do you believe that people with chrysotile exposures who develop pleural changes have a decrement in DLCO?

A. I have seen that --

Q. Okay.

A. -- in some patients with chrysotile exposure, but not a large number.

Q. If you treat somebody who has a chrysotile exposure and they have normal FVC, normal TLC, but a decreased DLCO, with fibrotic changes of the pleura, and no changes apparent on x-ray, would you believe that the decrement in DLCO was caused by the asbestos pleural disease?

A. Yes.

Q. Okay. So, this is not necessarily a Libby specific issue? Again, just like FEV1/FVC, we are not seeing some unique phenomenon in Libby which makes DLCO an applicable lung function measurement whereas it would not be with respect to other exposed cohorts, correct?

A. Probably not. Although I think the frequency and the extent of it in Libby is far more than what has been seen elsewhere.

Now, to partly answer your question, also there's been a recent article in the last couple of years from Australia, from Wittenoom, of DLCO decreases that

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basically is along the same line of things that I am saying about DLCO.

Q. Who wrote that article?

A. Oh, God. I knew you were going to ask me that. I was trying to remember who it was. It's in there.

Q. It is in your expert report?

A. It is in there. Somewhere in there.

Q. Okay. So, just to summarize, the FEV1/FVC issue, that is not a Libby-specific issue? That is a general issue that is applicable to those exposed to winchite, richterite and tremolite, as well as chrysotile, correct?

A. But I think you need to put that into the perspective of the extents of severe pleural disease in chrysotile and the frequency with which it's seen, which is considerably less. And in addition to the fact that an awful lot of layouts in academic centers just have never bothered to do DLCO's.

Q. Well, I was speaking more about the FEV1/FVC issue, not the DLCO issue.

A. Oh. Well, then you had better repeat the question again.

Q. Sure. Sure. The FEV1/FVC ratio was more of a general criticism, not necessarily a Libby-specific

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one, correct?

A. Yeah. I think so.

Q. The DLCO one certainly is applicable to both those exposed to winchite, richterite, tremolite, as well as those exposed to chrysotile, but the frequency and extent with which you observed this phenomenon is greater in those exposed to winchite, richterite and tremolite --

A. Correct.

Q. -- correct? That's correct?

A. Yes. I would agree.

Q. Okay. And again, the DPT issue, the diffuse pleural thickening issue, that is much more of a Libby-specific issue, correct, insofar as those exposed to winchite, richterite, tremolite develop --

A. Do you mean as far as the --

MR. HEBERLING: Objection. Objection, unclear as to what the DPT issue is.

Q. (BY MR. STANSBURY:) Let me rephrase that for you. The issues we discussed earlier with respect to diffuse pleural thickening, and those would be including requiring of the blunting of the costophrenic angle, coverage of over 25 percent of the pleura, and three millimeter thickness.

Those were much more applicable, those concerns are much more applicable to those who have been

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exposed to winchite, richterite and tremolite as opposed to chrysotile, correct?

A. Yes.

Q. Okay. Now, I believe these were the five issues we discussed in Exhibit 2 at the very beginning.

Now I want to ask what your basis for this belief is. And I think throughout the course of our discussion it became somewhat clear, but just so we are on the same page, is it fair to say that these opinions that you have are based in large part on your experience as a pulmonologist who has treated individuals exposed to winchite, richterite and tremolite?

A. In large part, it is.

Q. Okay. So, in large part this is based on your diagnostic practice, correct?

A. Well, it's a diagnostic practice, but also gathering all of the data together and looking at it in large groups, and looking at people who died from it as well. So --

But, yes, it comes from my experience. Where else would you get the experience? I mean, except for having seen, you know, 1500 or more of these people.

Q. Okay. Let's kind of unpack that statement. So, it's based in part on just the day in, day out experiences of being a diagnostic -- Strike that.

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Your opinions are based in part on your day in, day out experiences of a pulmonologist, treating these individuals, correct?
A. Right. Let me -- Go ahead.
Q. Your opinions are also based on these analyses you conducted involving data obtained from people in your diagnostic practice, correct?
A. That's correct.
Q. Now, let's identify those analyses. One would be your 2004 paper published in the American Journal of Industrial Medicine, correct?
A. That's true.
Q. What was the title of that paper? It was kind of long. But just so we are clear.
A. It was --
Q. Is it Asbestos-Related Pleural Disease Due to Tremolite --
A. Yeah.
Q. -- Associated with Progressive Loss of Lung Function?
A. Progressive Loss of Lung Function, yes.
Q. Okay. That's one, correct?
A. That's one.
Q. Would another be your CARD Mortality Analysis?

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A. Yes.
Q. And the death rates you observed in the lung function measurements and the radiographic abnormalities that you observed of the individuals in that CARD Mortality Analysis also informs your opinion, correct?
A. Yes.
Q. Are there any other similar analogies you've done of people in your patient group that informed your opinion?
A. Well, we've been challenged many times concerning radiographic readings and things like that. So, there's studies that are in here relative to comparing x-ray readings with outside sources.
Q. So, this would be the HNA comparison?
A. That's the HNA comparison. Comparison with Shipley and Molina. And, you know, Lynch's, Newell's, Decker's, a radiologist in Kalispell, myself, Gordon Teel, Brad Black, as to almost basically a scoring of who read how.
And then more recently, of course, getting backup from several real experts from Selikoff's lab in Mt. Sinai, from Steve Lavin and Arthur Frank, who has basically looked at all of this stuff and have concurred with how we read the films.
Q. Okay. So, we're going to call this the HNA

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comparison, which was, as you said, I am looking at Shipley, Molina, Lynch, Newell. There you are comparing your interpretations of radiographs and CT with theirs, correct?
A. Yes. But what we're doing and mostly what we did then and what we're doing now is, we continue to do on a regular basis, is be sure that we're on track.
And, so, we're utilizing all of our resources to have people look at films that we can. And, so, that's where that data comes from.
And of course more recently we've got some people that have been doing asbestos work for 40, 50 -- 40 years or so.
Q. Now, just so I'm clear, how does the comparison of reads, and presumably analyses that demonstrate how your reads compare to others and which ones may be more accurate, how does that inform your opinion as to the definition of diffuse pleural thickening, the use of FEV1/FVC, or the use of DLCO to determine impairment?
A. That has nothing -- That's tangential to that.
Q. Okay.
A. These other opinions are formed based upon looking at the patient.

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Of course, you know, we've looked at all of these patients, contrary to Grace's experts, none of whom have been looked at really carefully. Well, maybe a few. But very few have been looked at by anybody else.
We've looked at them. We've taken their histories, their exposure histories. Done physical exams on them. Followed them for periods of time. Watched what's happened to their x-rays. Looked at their films, their CT-scans, discussed it with other people.
It's a lot of work that goes into what you see as a final product on a chart. And then it's done year after year. And, you know, if we find something that was wrong, we correct it.
Q. So, you've actually been able to lay eyes on these people, take their vital signs, conduct physical examinations, you know, be in the same room with these individuals, correct?
A. Oh, sure.
Q. And, so, you're able to offer opinions, in your mind, that somebody who has not had that opportunity, cannot?
A. Yeah. I think so.
Q. So, the fact that somebody, let's say, such as Dr. Stephen Haber?
A. Stephen who?

Q. Stephen Haber. H-A-B-E-R.
A. Is that what his first name is? I didn't know that was his first name.
Q. That fact that he has never examined any of these people limits the opinions he can reach, correct?
A. Very, very much so.
Q. So, without that opportunity, he can't have the same information that you have, correct?
A. True. All he's done is chart reviews, and looked at x-rays, and probably has not had the opportunity to look at everything sequentially. There's too much.
Q. All right.
A. It's taken us eight years to get to this point, and he's up there for two days? Come on, you know.
Q. But it's fair to say that the opportunity to actually examine individuals is very critical to reaching informed opinion about disease, correct?
A. That's true.
Q. Okay. So -- But getting back to the point about the basis of your opinion, you said that the HNA comparison was, as you put it, tangential to the DPT, FEV1/FVC, and DLCO opinions, correct?
A. That's correct.

Q. However, the 2004 published paper, as well as the CARD Mortality Study, those were supportive of those opinions regarding DPT, FEV1/FEV and DLCO, is that correct?
A. Well, to begin with, the 2004 paper was actually written in 2001. It takes several years to get something published.
Q. Understood.
A. And we've learned a hell of a lot more since that time. Clearly, I have.
I mean, that was written about a year, year-and-a-half after CARD was started, before it finally got published. And this is true of all papers.
The same with that mesothelioma paper. That had been -- that was finished almost two years ago before it was published last fall.
So, one forms opinions as you go along.
These opinions are opinions that have become more and more evident as the criteria were published, and became evident that all these people were not going to be covered. And that's what triggered that Mortality Study. Because there were so many of these people that died of this disease, it wouldn't be considered to have compensation.
Q. So, although your understanding has evolved

since the 2004 published paper which was written in 2001, it is fair to say, though, that that is informative for your overall opinions with respect to DPT --
A. Yeah. That's actually informative. And as you may or may not know, 36 of those people died.
But also it's the ongoing follow-up of the whole group of people in the clinic and the progression of things. And that's another paper which is in the process of being written right now.
Q. Okay. Well, let's hold that thought for a second. When you mention this ongoing process, that goes back, though, to your diagnostic practice, correct?
A. Well, yeah. I mean, that all started in the '80s.
Q. Right. But what I'm trying to just get my brain around is understanding what forms the basis of your opinion. The diagnostic practice is obviously the backbone of this, correct?
A. Sure.
Q. And --
THE VIDEOGRAPHER: I'm sorry, Doctor. Your hands are covering your face. Sorry.
THE WITNESS: Sorry.
Q. (BY MR. STANSBURY:) However, you had mentioned that some analysis of individuals within your

practice had been informative to your opinions as well. And among those are the CARD Mortality Study, which is in your expert report, correct?
A. Uh-huh.
Q. Yes or no.
A. Yes.
Q. Okay. But it has not been published in the peer review literature, correct?
A. No, it has not.
Q. Okay. The 2004 paper which was published is instructive to your opinions, correct?
A. Right.
Q. Are there any other analyses that are relevant to your opinions regarding the definition of diffuse pleural thickening, the use of FEV1/FVC, or the use of DLCO?
A. Well, yeah. The opinion comes about because you look at somebody in the clinic that has -- and maybe you've already answered the question -- but you look at somebody in the clinic who is severely impaired, okay, and has an isolated DLCO. That's one example. Okay?
Or they don't have blunting of the angles but have diffuse pleural thickening otherwise. Very short of breath. Maybe on continuous oxygen.
And you look at the criteria. And you find

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that, no, they aren't going to be -- there's no way that they're going to fall through that -- they're going to fall out when it comes time to request compensation for their asbestos disease.

Q. I understand. But that goes back again to your diagnostic practices, right?

A. It goes back to my diagnostic practice, yes.

Q. I'm just trying to make sure I understand. So, the diagnostic practice, once again, critical to these opinions.

The 2004 paper also is informative to these opinions. The 2007 CARD Mortality Analysis is also informative for your opinions on DPT, DLCO and the FEV1/FVC ratio.

Just so we're clear, are there any other analyses that you have done that are supportive of those opinions?

A. There are so many analyses over the years of one sort or another, most of which don't get published.

Certainly I have looked at an awful lot of people with obstructive changes who would fall out of compensation and who's obstructive disease is solely related to their asbestosis, but they don't meet the 65 percent requirement for FEV1/FVC ratio. They have low residual volumes. Normal total lung capacities. Things

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like that. They do not meet the criteria. And we have a lot of those. And they have a lot of interstitial disease.

Q. Once again, but that is an opinion you have reached based upon your diagnostic practice.

What I am trying to do, understand here, Dr. Whitehouse, is identify the various sources of information.

There is this broad category, your diagnostic practice, your many years of working as a pulmonologist, that is very fundamental to your opinions, correct?

A. That's true.

Q. The CARD Mortality Study, the 2004 published paper. Anything else that forms the basis of these opinions?

A. Well, the basis of the opinions concerning radiology. We've done comparison studies not only with HNA but also with Dr. Weill, studies that he had done.

Q. But, again, as you mentioned earlier, that does provide information on how you're doing in terms of recognizing radiographic impairment.

But as you said, that was tangential to the fundamental questions of the definition of pleural disease, use of DLCO and the use of the FEV1/FVC criteria, correct?

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A. That's correct.

Q. Okay. So, it's fair to say that what we've identified, then, that is what's forming the basis of your opinion?

MR. HEBERLING: Objection, vague.

THE WITNESS: Your tone and the way you say that tends to minimize what the private practitioners do.

Q. (BY MR. STANSBURY:) I'm not attempting to minimize it. All I'm trying to do is just get a list. At this point I just want to make sure I understand what the bases are.

And the diagnostic practice incudes your analyses of how many individuals?

A. What do you mean? In the total clinic --

Q. Yes.

A. -- that I have seen? I don't know the exact number. We've got 1800 cases. I have seen most of them.

Q. So, there are 1800 people whose patient care over the years is relevant to your opinions in this case?

A. Yes.

Q. Okay. And do you know how many of those individuals for whom you have produced medical records in this case?

A. Basically, how many -- It's however many are

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involved in the lawsuit for the bankruptcy -- before the bankruptcy was filed. I assume that's the number.

Q. Okay.

A. And I think there's seven or eight hundred, something like that.

Q. Seven or eight hundred. But you mentioned 1800 people, correct?

A. Oh, yes. There's an awful lot of people. And we continue to diagnose people on a regular basis.

Q. And in your mind you don't segment these seven or eight hundred people and think, this is the basis of my opinion. You look at all 1800 --

A. We look at them all, yeah.

Q. Right. So, all of them are relevant to your opinion?

A. Yes.

Q. Okay. Just want to make sure we are clear on that.

So, the diagnostic history of these 1800 people, the 2004 study, the CARD Mortality Analysis, those are the fundamental bases of your opinions, correct?

A. Yes. I guess.

Q. Okay.

A. That's fair enough.

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Q. Thank you, sir. You also mentioned another study that was ongoing. What was that?
A. We have progression.
Q. You mentioned, you were going to publish something soon. I just heard that.
A. Well, we've had a number of people who have rapidly progressed, which has not been reported in the literature before, with asbestos diseases. And I'm in the process of assembling a number of cases. I've actually got about 40 cases.
Q. 40 cases.
A. I think total. But I am sort of narrowing them down to the ones that we can -- You know, there are some practical aspects, if you are going to put something in a paper and you want to demonstrate something with x-rays so they can be seen, and you've seen x-rays in these papers, they are hard to read. And, so, basically trying to decide which cases to use.
Q. And how far along are you in this process?
A. Oh, I've written a draft.
Q. Pardon me?
A. I've written a draft. But I keep adding cases because I keep seeing more. And so I add a case, and then I don't know what I'm going to do on it.
You know, Steve Lavin, who's involved in

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that, wants me to keep it to about six cases to keep it simple. And, so, I'm having trouble deciding which six --
Q. Understood.
A. -- I will use.
Q. And Steve Lavin was the person from Selikoff's lab from Mt. Sinai?
A. Mt. Sinai, yeah.
Q. Okay. And have you sent Steve Lavin a draft?
A. Oh, yeah. He's seen a draft. In fact he's written part of it. In fact, he's been upset with me because I haven't gotten any further along. But I've been doing all of this legal stuff all summer, so I haven't had time.
Q. When did you first send him a draft of this?
A. I didn't send it to him. He did it in Libby. He comes out there. He hasn't been out there since -- I think it was last spring. We're pushing a year since I've really done very much on it, except collect more cases.
Q. Okay. But he came out spring of 2008?
A. I think that's when it was.
Q. Okay.
A. April or May, somewhere in there.
Q. All right. Did you have a draft for him

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then?
A. Oh, yeah. And then he chewed it up and rewrote a bunch of things, and then I rewrote some. It's sitting, waiting for more work.
Q. Can I see a draft?
A. No.
Q. Why not?
A. Because I don't have anything that's in a position that I would give it to you.
Q. Okay.
A. It hasn't been introduced as evidence. And I'm not going to -- Until I get ready to publish it, it's not your business.
Q. Okay. But these individuals, they are individuals who have rapid pleural disease, correct?
A. Yes.
Q. And you're forming opinions on them, aren't you?
A. Yes.
Q. Okay. And those opinions are obviously very relevant to how we assess pleural disease, correct?
A. Yes.
Q. Okay. But you do not want to share that with this court or any of us?
A. No, I'm not going to. Because it's --

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MR. HEBERLING: I'll insert an objection also.
We have a series of rapid progression cases, which is what we're using in this litigation.
So, as to what he publishes, you know, there are rules of disclosure before publication, you know. He has to follow those.
Q. (BY MR. STANSBURY:) Let's look at this list real quick.
A. Some of the cases are in there already.
Q. Oh, I understand. Let's take a quick look, just so we are on the same page. Because it sounds like a study that will be very instructive to your ongoing opinions about pleural disease in Libby, correct?
A. Yeah.
Q. Let me make sure I find --
A. We are providing drafts. Basically, it's just something you don't do until after you've got the thing pretty well written. I don't know what I'm going to take out of it, you know, especially when you have three authors or four authors, they all have an idea of what to do.
Q. Will Lavin be a potential author?
A. Who?
Q. Lavin.

A. Oh, Lavin will. Brad Black. Mark Heppe is very good at reading things.
Q. Is this it right here?
A. Yeah.
Q. Exhibit 6?
A. Yes. That's part of the list, yeah.
Q. That's part of the list.
A. In fact that is the whole list.
Q. All right.
A. And you have the names here obviously, because most of them have legal actions.
Q. So, if I could have that back for one moment, please.
A. Basically, to explain what's on here --
Q. Sure.
A. -- there's 22 on here out of the 40 or so that I have. And I culled out these.
And then I've taken the dates here and put down their FVC, FEV1, DLCO sequentially in each one. And I'm not sure whether you have the x-rays or not.
Q. I think we have some of them.
A. You may have -- you may not have all of them. Because then I have culled it down to about six. And then I've been working on it since then.
And each time I do that, then I have to

rewrite things because I have a new history to put in there, number of other things.
Q. Okay. So, this is Exhibit 6 to your report, which is Exhibit 3 in this deposition.
A. Yeah.
Q. And --
A. I'm sorry. I forgot that was in there. I'm sorry.
Q. I see 22 names on this list, some of whom, I just have initials.
MR. STANSBURY: And I take it those are not your clients, Mr. Heberling, is that correct?
MR. HEBERLING: Yes. That's correct.
THE WITNESS: In view of, you know, confidentiality issues.
Q. (BY MR. STANSBURY:) Understood. I respect that.
A. Have to obey HIPAA laws.
Q. And the people whose names are here are claimants, is that correct?
A. Yes.
Q. All right. So, Robert Mack is on the list.
A. Uh-huh.
Q. We have next HC, and that's obviously somebody whose confidentiality we are protecting.

A. Yes.
Q. Wendy Challinor.
A. Uh-huh.
Q. Ron Masters.
A. Uh-huh.
Q. Larry Hill.
A. Uh-huh.
Q. Ken Moss.
A. Yep.
Q. Jeff Swennes, S-W-E-N-N-E-S.
A. Uh-huh.
Q. Lonnie Kelley, K-E-L-L-E-Y.
A. Uh-huh.
Q. Clinton Hagen, H-G-E-N.
A. H-A-G-E-N.
Q. Excuse me. Bruce Cole. Al Dickerman. Andrew Wright, W-R-I-G-H-T. Dean Atkins. Jack Deshazer. And Deshazer is spelled, D-E-S-H-A-Z-E-R. Walt Torgison. Art Schauer. And Schauer is spelled S-C-H-A-U-E-R. Ruben Fellenburg, F-E-L-L-E-N-B-U-R-G. And then WW.
Those are the individuals on this list, is that correct?
A. Six of those are dead. I think six.
Q. Okay. And, so, by my count that's one, two,

three, four, five, six, seven, eight, nine, 10, 11, 12, 13, 14, 15, 16, 17, 18 people on the list.
A. Uh-huh.
Q. All right?
A. Yep.
Q. Okay. So, those are the names you've produced to us. But you've mentioned there are up to 40 people who may be in your paper, correct?
A. No. No, no.
Q. Oh. Let me rephrase that.
A. You said that wrong. What I'm saying is, that 40 cases --
Q. 40 cases.
A. -- I found 40 cases that meet the criteria that I originally set out, which was rapid changes within five years.
Q. Let me rephrase that, then. You've identified 40 people who rapidly progressed from pleural disease to interstitial disease, is that correct?
A. No. There's one that's developed severe interstitial disease. But most of them are increasing in pleural disease.
Q. So, these are people who have had rapid progression --
A. Actually, I'm wrong about that. There are

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two at least that have had rapid interstitial disease.
Q. So, your contention --
A. I'd have to look at the list again to sort it out.
Q. So, your contention therefore is that these people have pleural disease only, with the exception of one or two, and it's been progressing rapidly, correct?
A. Right.
Q. All right.
A. Yeah. This paper is not restricted just to pleural disease. This is rapid progression from Libby asbestos disease.
Q. Okay. And some of these people, for example, Ken Moss.
A. Uh-huh.
Q. He's a former Grace worker, correct?
A. Yeah. He worked there a couple of months, I believe, or maybe a year.
Q. Perhaps dating back to 1973?
A. I think quite a while ago, yes.
Q. Okay. Even did work as a dry mill sweeper, didn't he?
A. Actually, unless I have all the data on that, I won't remember each one individually. Okay?
Q. But fair to say, he is a former Grace worker,

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correct?
A. Yeah.
Q. And are you aware that in September of 2001 Dr. Becker read a CT as finding interstitial changes for him?
A. He may have. I'm not -- I'd have to look at my own notes about the thing.
Yeah. No, some of these people do have interstitial changes.
Q. Okay.
A. A lot of them do.
Q. So, what's the progression we are talking about, then?
A. We're talking the whole thing. But we are talking about rapid.
Q. So, what is rapid?
A. You know, you make the assumption that asbestos is a slow disease over 30 years.
We are talking about a period of very rapid change in a short period. Pulmonary functionalists will tell you -- tells you the answer about the time frame.
You see marked decline in pulmonary function over a very short period of time. That's the -- that, along with the radiograph, are the two criteria. Whether it's interstitial or pleural doesn't matter in this

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study. This relates just to patients that have Libby asbestos disease.
Q. Okay. So, the title of this exhibit then wouldn't be rapid progression of pleural disease only, correct?
A. No. Probably not.
Q. This is really progression of asbestos disease generally, correct?
A. Yeah. You're looking at drafts. I mean, this is the way I keep stuff on my computer.
Q. Okay.
A. Okay? Hopefully I can still find it. I don't know if you have had that experience. But when you've got so much stuff like this, I have to put something in that allows me to find it relatively easily.
Q. So, you mentioned earlier about the role of the diagnostic process and your diagnostic history, the role that's played in forming your opinions, correct?
A. Yes.
Q. Okay. I want to talk a little bit about some of your diagnostic process. You are familiar with Dr. Becker, correct?
A. Yeah.
Q. And who is Dr. Becker?
A. He's a radiologist at St. John's Hospital.

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Q. Okay. And where is St. John's Hospital?
A. Across the street from CARD Clinic in Libby.
Q. Okay. And often people will be given an x-ray or a CT by Dr. Becker, correct?
A. Yeah. He reads them. He reads for the hospital.
Q. And you get copies of his reads, correct?
A. Yes.
Q. And they're part of the diagnostic process, aren't they?
A. That's right.
Q. Sometimes you agree with him, sometimes you disagree, is that right?
A. I think that's true of medicine in general, yeah.
Q. All right.
A. Actually our agreement with Dr. Becker actually is really very high. He's actually pretty good. He has sometimes what we think are lapses. He likes to use the word "subtle."
Q. Subtle.
A. Which drives me right up a tree. But then on the other hand I have the pulmonary function that goes along with it.
Q. I'm handing you what's been marked as Exhibit

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4. This is a February 2003 -- Excuse me, February 23 -- Strike that.

I'm handing you a February 23rd, 2006 chest x-ray read by Dr. Becker.

A. Yeah.

Q. And I'm reading under Impression, and tell me if I have read this correctly. "Extensive pleural parenchymal changes, consistent with changes from previous asbestos exposure."

Did I read that correctly?

A. That's correct.

Q. This is probably somebody who's got, it looks like, interstitial changes, correct? That's what parenchymal means, right?

A. Yeah. But I have no idea, because that may refer to a number of things. It may not refer to something that is diffuse. It may be just something that is localized.

Q. He says above, "There are extensive calcified pleural-based plaques noted bilaterally," correct?

A. And then he said there are "mildly prominent interstitial markings."

Q. Okay. But this is somebody who has been exposed to asbestos, correct?

MR. HEBERLING: Let him finish the

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answer.

THE WITNESS: No. I'm finished.

Q. (BY MR. STANSBURY:) This is somebody who has likely been exposed to asbestos, correct?

A. Right.

Q. He has calcified pleural plaques, right?

A. Yes.

Q. And, you know, he says, mildly prominent, but there are certainly interstitial -- He says "probably represents interstitial fibrosis," correct?

A. Correct.

Q. So, this is probably somebody who has asbestos exposure and it looks like they are developing disease, correct?

A. Well, I mean, he had fairly well developed disease.

Q. Okay. So, let's move on to Exhibit 5. I'm handing you what has been marked as Exhibit 5, and this is an April 2nd, 2008 chest x-ray, also by Dr. Becker.

A. Uh-huh.

Q. And here the impression is "Extensive pleural parenchymal changes, consistent with previous asbestos exposure, stable from the prior examination."

Do you see that, sir?

A. Yes.

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Q. Again, this is probably somebody with asbestos disease, right?

A. I would assume so.

Q. Okay. And, so, when you as a pulmonologist get this read back from Dr. Becker, this is certainly something where you would think, okay, problem here, this person has got disease, correct?

A. Well, let me tell you how we use x-ray reports.

Pulmonologists, I have been reading x-rays and reading for a very large group, I have read for a very large group since about 1977, until I retired, reading all the films.

I read the radiologist's interpretations to be certain that there's not something that I might have missed. Because I always think it's a good idea to see, you know, second read on that may be helpful. I always look at them.

Q. Uh-huh.

A. Beyond that, I may not agree with the word extensive, I may not have even agreed with parenchymal, if they've got a lot of en face plaquing. That's how pulmonologists basically use the x-ray reports.

You know, general practitioners, family docs, use it literally, for the most part.

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Q. So, as a pulmonologist, when you get this report back from Dr. Becker and you see language like this, this suggests that this person has some asbestos disease, correct?

A. Yeah.

Q. I'm going to hand you what has marked as Exhibit 6.

A. Okay.

Q. This is a July 7, 2008 CT read from Dr. Becker. And again, the impression, "Extensive pleural parenchymal changes consistent with previous asbestos exposure."

Is that correct? Am I reading that correct, sir?

A. Yes.

Q. Once again, this suggests this person has asbestos disease, and that's how you understand Dr. Becker's words here, correct?

A. Sure.

Q. Okay. I'm going to put these here. I'm going to call these category A. These three exhibits are examples where you've just got clear statements from Dr. Becker.

Now I am going to hand you Exhibit 7. And this is going to contain that language you don't like.

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"Impression. There are some subtle changes that could feasibly be due to previous asbestos exposure."
A. Uh-huh.
Q. I read that correctly?
A. Yep.
Q. And, so, that's one where you just kind of look at that and scratch your head?
A. No. I don't scratch my head. Dr. Becker actually, you know, whether he wants to call it subtle or I want to call it something else, I have more information than he has.
The fact, the more important thing is, the fact that he read it.
Q. Okay. Again, this read from Dr. Becker, would the word equivocal be a fair description of his read?
A. That's not an equivocal read. Knowing Dr. Becker, it is not equivocal.
Q. But it is certainly not as clear. He is describing these as subtle. These are not as clear as the category A reads, right? He is hedging his bets here, right?
A. That may very well be, right.
Q. I am handing you what's been marked as Exhibit 8.

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A. I think hedging his bets may be a good term.
Q. We'll use that term, then.
A. Okay.
Q. This is a -- Excuse me. This is an August 11, 2008 chest x-ray read, also by Dr. Becker.
A. Uh-huh.
Q. And here under the chest x-rays it says "There is some pleural thickening noted, stable from the previous examination. No calcified plaques are noted. No obvious interstitial fibrosis."
And the impression is "Pleural-based changes, may or may not be due to previous asbestos exposure."
Once again, is this a read where, as I have said earlier, kind of hedging his bets, so to speak.
A. Well, actually, not. He's correct in saying may or may not be due to, because he does not have the information --
Q. Okay.
A. -- to make that diagnosis.
Q. Okay.
A. And that's not his business. The radiologist or the general practitioners of chest radiology, they read all kinds of things.
Whereas people like myself or like orthopedists who read bones, become very expert at

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reading nuances, and pick up a lot more sometimes on x-rays.
What he reads may or may not be due to that. He doesn't want to make that diagnosis. And he shouldn't. Radiologists basically should be descriptive, maybe give you a differential diagnosis, but not make a definitive diagnosis.
Q. And while "consistent with" is not a diagnosis, in category A he is saying, "pleural parenchymal changes consistent with previous asbestos exposure."
A. Yes.
Q. This is certainly not as strong of language as that, is it? May or may not. Again, that is more of hedge betting --
A. But if you look at his readings over a long period of time, you will realize that some days he's in a subtle mood and some days he's in a different mood.
Q. Okay.
A. And I don't fault him for that, you know.
Q. Okay.
A. There's days, you may feel crummy some days and some days you write differently.
Q. I'm handing you --
A. There's nothing wrong with that.

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Q. I'm handing you what's marked as Exhibit 9, and this is a June 25th, 2007 read from Dr. Becker.
A. Yeah.
Q. And again the Impression, "Minor non-specific pleural thickening. May or may not be due to previous asbestos exposure."
A. Uh-huh.
Q. Did I read that correctly?
A. Yeah.
Q. That's very similar to the previous three -- two reads that we just looked at, Exhibits 7 and 8, correct?
A. Yep.
Q. And, again, would it be fair to put these in a category B, where Dr. Becker is again not being as decisive or definitive, but again, as I said, more hedging his bets on these? Is that --
A. Oh, I don't think you should do that. I don't think you should do it.
It's a radiologic reading that shows something that is consistent with asbestos disease. He's done his job in the reading of that. He's not seen anything else that could be a significant problem, like a nodule or something like that.
The reading is somewhat helpful to us in that

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regard. He's done his job.
It doesn't matter to me whether he reads it as extensive or subtle. And in fact some of the ones he will read as negative, and I disagree with him. And there have rarely been occasions where I thought the thing was negative and he's read something.
I mean, that's the way it goes in this business.
Q. I understand. However, if you as a pulmonologist get this read back from the radiologist, and the first three exhibits that we looked at, what I'm calling category A, we see much more, I would say, clear reads in terms of the finding of an asbestos-related abnormality on x-ray or CT than we saw in these category B reads.
A. If you think that --
MR. HEBERLING: Objection. Asked and answered.
THE WITNESS: If you think that makes any difference on how I deal with anything, you're absolutely wrong.
Q. (BY MR. STANSBURY:) Why?
A. It makes absolutely no difference.
Q. Why?
A. Because I read my own x-rays, and I have

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pulmonary functions, I have a patient in front of me, and I have their symptoms and their chest exam, and their complaints of pleurisy, and I have all of these other things that I have to use.
All he's done -- You know, if he didn't read these x-rays at all, it wouldn't make a darn bit of difference to us. When I was reading for my group, which I did for, you know, God knows, 20-some odd years, along with my partner, we read all of them for a group that finally wound up being 27 doc's, we'd read a lot of x-rays every day. We didn't have a radiologist being involved at all. We were considered competent to read x-rays in their own right, as a board-certified pulmonologist.
So, whether he read these or not probably doesn't make a whole lot of difference.
Q. So, you, as a medical professional, are not interested in what the radiologist across the street has to say?
A. I'm interested in it only because of the fact of the possibility he may see something that I didn't see. And I think it's always a good idea, if there's something available, to look at it. I mean, I just don't file it. I do look at it. Okay? He's required, the hospital's required by law to have a radiologist read all

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of these. Okay?
Q. You mentioned the possibility of him seeing something you did not see.
A. Possibly.
Q. What about the possibility of him not seeing something that you believe that you saw?
A. That may happen, too.
Q. Okay.
A. So what? I mean, that really doesn't make a whole lot of difference to me.
Q. It makes no difference if a radiologist does not read a x-ray or a CT the same way you do?
A. No. It doesn't make any difference to me at all.
Q. Why not?
A. Because I am better at it.
Q. You are better than Dr. Becker?
A. Yeah. You are damn right I am.
Q. Okay. What about Dr. Lynch?
A. I don't know Dr. Lynch. He's a good radiologist. I know that. But he's spotty, too. If you look at his reports, you'll see that he may have read four different films in that screening program from ATSDR, and read changes on two and not on two other ones. Okay?

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So, technique may go into it. There's all kinds of things that could go into this.
Q. Who is better than you at reading x-rays or CT's?
A. I'm sure there are pulmonologists that are a whole hell of a lot better than me. And there's also pulmonary radiologists that may be better. Gordon Teel's a good example of that.
Q. So, you would trust a Gordon Teel read? If he did not see something you saw, you would second-guess your original read?
A. Well, of course, what I do, and used to do all the time, was I'd give Gordon a call, or I on several occasions have taken x-rays up to the hospital and said, "I'm not sure what we're talking about here. What I'm seeing and what you're seeing seem to be different." And then we'll hash it out.
Q. How often do you do that with Dr. Becker? How often do you call Dr. Becker and say, "I'm not seeing this," or "You're not seeing this, let's have a meeting of the minds"?
A. Well, when he doesn't see something, I don't really pursue it particularly. If he sees something that I don't see, and particularly if I'm having some problems really seeing it, I get on the phone. And we both have

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it on computer. So we can look at the same thing, same x-ray at the same time.
Q. Now, these asbestos diseases, these are life-threatening diseases, correct?
A. In the long run, yes.
Q. So, if another medical doctor, in this case, a radiologist, reads a piece of radiology such that he does not find an abnormality --
A. Uh-huh.
Q. -- suggesting that this person does not have a life-threatening disease --
A. Uh-huh.
Q. -- you wouldn't call him up to ask about that?
A. No, I probably would not.
Q. Why not?
A. Because of the fact that I've got all of the other information. I've probably even got old films that may have shown things and he doesn't see them on the CARD film, or he is very little experienced in reading this sort of stuff.
Q. Do you tell your patients that, that "Dr. Becker disagreed with me"?
A. Oh, sometimes I do, sometimes I don't.
Q. Why wouldn't you tell a patient that another

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medical professional did not think you have a life-threatening disease?
A. You know, that's probably -- would be the very best way to confuse an issue. Because basically if there is minimal changes that are hard to see, that I see them and he doesn't, I explain that to the patient. I explain it. I say, "Look, these look a little bit equivocal, and I'm not sure whether -- what we're seeing," and then I get a CT-scan.
And then I sit down with the patient with the CT-scan and I show him what I see.
And if you look through a large series of things that we've done that way, you will find that the CT-scans more often than not show changes on the CT that I read as equivocal on the x-ray and the radiologist read as negative.
Q. Nonetheless, don't you think the patient is entitled to know that another medical professional does not think that they have disease?
A. You know, you're asking a question that, you know, I'm the one that's the person that a buck stops with me, okay? You know, what are we talking about here?
We're talking about somebody that may have a minimal disease at this point, when we are talking about where we disagree, like there may or may not be a plaque

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here. Okay?
And, yeah, maybe sometimes I have said, "Well, Dr. Becker didn't see this. I think this is here. I'm going to get a CT and we'll talk about it." There's nothing wrong with that.
Q. But there are --
A. You're trying to make -- you're really -- you're trying to make this into something as a wrong way of practicing medicine. And it is not. This is very appropriate in medicine. And I think that -- especially when you are talking about minimal disease.
So, don't try to put me on the defensive by saying that I didn't follow through or do care properly because I didn't necessarily tell the patient in the same terms exactly what Becker wrote.
Q. I am just --
A. That is wrong.
Q. Well, I'm just trying to understand why that is wrong.
A. I've told you why it's wrong. Because I follow through with them.
Q. All right.
A. And I've got another visit that's coming up that I may go over it with the patient, too.
Q. But don't you believe a patient has a right

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to know if another medical professional has disagreed with your opinion?
MR. HEBERLING: Objection, asked and answered.
THE WITNESS: Yeah. I'm not even going to answer.
Q. (BY MR. STANSBURY:) Why not?
A. Because I have answered it. Okay?
Q. You've said --
A. You're pushing me to say that I'm practicing wrongly because I don't tell a patient when Dr. Becker doesn't see something. Sometimes there are obvious things that he doesn't see. Okay?
There's obvious things that a number of other radiologists have not seen as well, that are very apparent when I look at it.
I've got other people in that clinic that I can show x-rays to. I've got people all over the place that I can show it to.
Q. And that's --
A. There's no reason why I have to tell them that Dr. Becker didn't read this when there's something that's there and it's apparent. And I can show it to the patient that it's there, and I can show it to Brad Black or to Mark Heppe, and if they agree with it, or if they

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don't agree with it, then we are dealing with an equivocal situation.
But you are making it out that I don't tell Dr. Becker, and there's something -- or tell them that Dr. Becker read it as negative and there's something wrong with that.
That is absolutely wrong, and you are putting the wrong context on that, and I am really objecting to it.
Q. Okay. Well, I am going to hand you Exhibit 10.
A. Sure. You'll show me some that say that, too, I'm sure.
Q. Again, here we see, this is an October 27, 2008 x-ray read.
A. Sure.
Q. This one, "No obvious pleural-based thickening or plaquing is noted. The patient had some mildly prominent chronic appearing interstitial changes." And under Impression it says, "No obvious evidence to suggest previous asbestos exposure."
A. Okay.
Q. This is very different from the previous two categories.
A. That's right. But if you are going to show

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me this one, you had better show me the chart and the x-ray.
Q. Okay. Let's look at another example. I'm handing you --
A. I don't know what point you're making here.
Q. I am handing you what's marked as Exhibit 11. This is a January 25th, 1999 CT read.
Okay?
A. Uh-huh.
Q. And on this one, this one's a little bit longer, the impressions are there are some, and would you help me with the pronunciation of that word, just so we are correct? Would you read the impression?
A. What? "Emphysematous changes in both lungs."
Q. Just wanted to make sure I had that right. What is that?
A. Emphysema.
Q. And what is emphysema?
A. Lung disease that may be related to smoking or other diseases, chronic asthma, a number of other things, that creates blebs or hyperinflation.
Q. Could you read the next sentence, please?
A. "Previous sternotomy with what appears to be coronary artery bypass draft. Small wedge shaped density in the lower left lung field is probably scarring."

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MR. STANSBURY: Did you catch that, sir?
COURT REPORTER: Uh-huh.
MR. STANSBURY: Okay.
Q. Are any of those statements consistent with an asbestos change, just so I am clear?
A. They might be.
Q. Emphysema is?
A. Yeah. They may be. If the guy's got interstitial lung disease, he may have blebs in both lungs.
Q. So, emphysema -- You're going to have to help me again, sir.
A. Emphysematous changes mean blebs.
Q. Okay. So, emphysematous changes --
A. Yes.
Q. -- could be caused by asbestos exposure?
A. Yes, they can. They can be caused by an asbestos interstitial disease.
Q. And the previous paragraph, I guess the second paragraph, it says, "The patient has had a previous sternotomy with sternal sutures and anterior mediastinal clips from what I suspect represents a coronary artery bypass."
Does that mean this person has had open heart surgery?

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A. Probably. I am sure it is, yes.
Q. "There are no pleural based densities or calcifications."
Did I read that correctly?
A. That is correct.
Q. So, this person, he finds changes consistent with emphysema, this person has had previous heart surgery, and he sees no pleural changes, is that correct?
A. That's correct.
Q. Okay.
A. That's what it says.
Q. I'm handing you what's marked as Exhibit 12. This is a March 23rd, 2006 read by Dr. Becker.
A. Uh-huh.
Q. And again the impression. "No obvious evidence to suggest changes from previous asbestos exposure."
Is that correct?
A. Sure. Yeah.
Q. Okay. Now, I want to go back to Exhibit 11. I'm handing you what has been marked as Exhibit 13.
Is Exhibit 13 the same as Exhibit 11?
(Pause in the proceedings).
A. I think so. The date of birth is the same.
Q. It is also a January 25th, 1999 CT read,

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correct?
A. Right.
Q. And the person's name is Raymond Siefke, spelled S-I-E-F-K-E --
A. Siefke.
Q. Siefke?
A. Uh-huh.
Q. Raymond Siefke?
A. Right.
Q. Date of birth, October 30th, 1921. And once again, as we discussed when we were looking at Exhibit 11, Dr. Becker is finding no pleural abnormalities, evidence of coronary bypass surgery, and changes consistent with emphysema.
Is that correct?
A. That's right.
Q. Okay. I'm handing you what's been marked as Exhibit 14. Exhibit 14 is a medical record by Guy Katz.
A. Uh-huh.
Q. It is dated November 16, 1994. It is also for Raymond Siefke, is that correct? Top left of the page, sir.
A. I think it's the same one.
Q. The date --
A. There are a whole bunch of Siefkes in town.

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Q. Right.
A. I'll grant you, it probably is.
Q. Okay. And the Impression here, "Markedly abnormal stress test with reduced functional aerobic capacity," and then "Positive EKG" -- excuse me -- "Positive EKG changes suggestive of ischemia."
Did I read that correctly?
A. Yes.
Q. What is ischemia?
A. Lack of blood supply.
Q. That is a heart disease, correct?
A. Yeah. I got him a bypass, so, this is the same person obviously.
Q. Right. And that can cause some serious problems with somebody having ischemia, correct?
A. Yes.
Q. Can cause chest pain?
A. It can.
Q. Can cause shortness of breath?
A. It can.
Q. And this was in 1994.
A. He had a bypass at some point in time after that. And my chart would indicate that.
Q. I'm handing you what's been marked as Exhibit 15.

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A. Uh-huh.
Q. This is a medical record generated by you, also for Raymond Siefke.
A. Uh-huh.
Q. The date of this report record is February 28, 2001. And it says as follows, at the top: "Raymond came back for a recheck of his asbestosis."
Did I read that correctly?
A. Yep.
Q. "I first saw him in January of 1999 with significant abnormalities on his chest x-ray and on his CT-scan at that time."
Did I read that correctly?
A. Uh-huh.
Q. Yes, sir?
A. Yes.
Q. "Dr. Becker, unfortunately, did not read the CT-scan as showing abnormalities."
Did I read that correctly?
A. You did.
Q. Okay. And I believe, looking at the date of January 1999, this is probably referring back to this Exhibit 13, which is a January 25th, 1999 CT read, correct?
A. I assume it probably is, yes.

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Q. Okay. Why is it unfortunate that Dr. Becker is not finding asbestosis within Raymond Siefke?
A. Okay. Now, I'm not even going to answer any more questions about this, unless I have the whole chart.
Q. Okay. Well, we're under a time constraint here put on by your counsel.
A. Well, I don't care about the time constraint, then.
Q. This is your patient, Dr. Whitehouse.
A. I know.
MR. HEBERLING: Objection, argumentative. Let him finish.
THE WITNESS: I want the whole chart before I'm going to do this. Because I don't know what else is written about this here. And I want the x-ray. Okay? You get me the x-ray, you get me the whole chart. Because I know this guy. I know this guy real well.
Q. (BY MR. STANSBURY:) Okay. Can I speak now, sir?
A. Okay.
Q. We were not given the x-ray or the CT for this person. The CARD Clinic did not have it.
With respect to his whole chart, we are not given whole charts. We have been given in drips and drabs, pieces of evidence from the U.S. Government or

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you, through the CARD Clinic.
We do not have Raymond Siefke or any of these individuals' complete records. We have --
MR. HEBERLING: Objection.
MR. STANSBURY: -- selected records that have been produced to us.
MR. HEBERLING: Objection, argumentative. There was a production in 2006 where you obtained six or seven hundred charts, and we have produced hundreds of others.
So, I don't think it's fair to characterize this as dribs and drabs.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, you said just a second ago you know Raymond Siefke very well.
A. I do. But, you know, what you've done is you've taken a couple things out of context in the whole thing.
I took care of this gentleman for a long time. Okay? If this is the same Raymond Siefke that I know, he committed suicide over a worsening of his lung disease.
I want the rest of the chart. Because there are other readings in the chart. There are readings when he went through screening with the ATSDR screening. I don't know what else there is. But I want that.

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Q. Dr. --
A. Just because you've got a Becker reading here that doesn't show anything, doesn't read anything on it, doesn't necessarily -- doesn't mean that I'm wrong.
What you're doing is trying to impeach me over that one reading, and I won't let you do it without the whole chart.
Q. Dr. Whitehouse, we're working under a very strict time limit.
A. Well, look it --
Q. Let me finish what I was going to say, sir. And you can respond. Okay?
A. Yeah.
Q. We are working under very strict time limits. Okay? We do not have all the time to look at the entire chart to the extent that you've produced the entire chart.
However, to the extent that you're willing to waive the time limits, I'm perfectly willing to sit down with the chart with you.
However, you're not going to prevent us from moving forward with this so that you can review somebody that you previously have stated you know well.
Moreover, to the extent that you want to supplement your opinion, you have another report, you can

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put in that report any other information you want on Raymond Siefke.
At this time in my deposition, with my limited time, we're going to go forward. And, again, to the extent that you want to supplement this in any way, you are welcome to do so in your next report, sir.
A. Okay.
MR. HEBERLING: Okay, Counsel --
MR. SCHIAVONI: I don't know that I am in accord with that last point. But I'm not ratifying that. That's all.
MR. HEBERLING: Counsel, if he has to have his chart in front of him and certain films to answer questions, he cannot professionally answer the question without that. And that's the end of it.
So, if you have another deposition, you can further inquire. You will have all the charts once again produced all over again by that time.
As you know, you've asked for all the charts on all the clients. So, you will have that by the time of the next deposition, and you can further inquire then.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, I respect your desire to look at all of the charts. We do have this chart. But again, if we're going to do that, it's going to be either off the record or we are waiving

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the time restriction.
You're not going to spend my time so you can familiarize yourself with a patient you know well.
Do you want to waive the time restrictions?
MR. HEBERLING: We will not waive the time restrictions. You can ask the questions at the next deposition.
THE WITNESS: You're -- Now, wait a minute. I've got something so say.
Q. (BY MR. STANSBURY:) I'm handing you what's been marked as Exhibit 17.
MR. HEBERLING: Well, let him finish --
THE WITNESS: I have something to say here. Okay?
You are basically trying to entrap me in this by not giving me the chart. If you've got the chart, and you know you've got the chart, you should have brought it here along with this stuff so that I could have looked at it. Okay?
If you had the x-rays, you should have brought it, or you should have told me you were going to discuss this and I would have had it.
MR. STANSBURY: I would loved to have had the x-ray and the CT for this person, but they are not produced to us.

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THE WITNESS: Hey, that's not my fault.
MR. HEBERLING: If you wanted to discuss Ray Siefke, you tell us, and we bring in the chart, we bring the x-rays, and, fine, we can discuss the patient.
Q. (BY MR. STANSBURY:) Dr. --
MR. HEBERLING: But he's got over 800 patients that he has seen. He can't remember every single piece in every record.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, I'm going to hand you what has been marked as Exhibit 17. "Ray came back for a one-year follow-up for his chest problems with a chief complaint that he can't breathe."
This is dated March 13, 2002.
"He is very short of breath. Much worse he says in the last year. He said he is waking up short of breath, which is a new phenomenon. He has had a little trouble with his prostate, troubles with Lasix when he gets it, which causes him to have a very large," is it "diuresis"? "He is breathing" -- Excuse me. "He says his breathing is progressively worse and he has an irritative cough. He doesn't cough much up. His sternum clicks. He has difficulty sleeping except on his left side."
Did I read that correctly?
A. That's right.

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Q. All right. Now, below Exam, you have his blood pressure at 170 over 80; heart: Negative except for the sternal click and the disruption of his sternum. And it says, "His chest x-ray now shows a rather marked worsening of the interstitial" --
A. No. You forgot something there.
Q. Oh. Sorry.
A. Why don't you read about the lungs?
Q. Sure. Sure. "Reveal bilateral rales, bilateral rubs in both posterior bases and the extent of these is new. At one time I heard a few rales in the past but this is a rather marked difference." Okay. So now we see rales, bilateral rales, is that correct?
A. Uh-huh.
Q. Okay. "His chest x-ray now shows a rather marked worsening of the interstitial change at the left base. He has had continuing loss of his FVC on his pulmonary function in spite of the fact that his diffusion seems pretty well preserved. His vital capacity is down to 76 percent. I exercised him and he drops to 84 percent with walking.
"I obtain oxygen for him and at night and when he was exercising. He is normally saturated at absolute rest. I think we should check him at six weeks. I did talk to him about what appears to be the

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progression of his asbestosis in the last one year and will see him again in six months."
Did I read that correctly, sir?
A. Yes.
THE VIDEOGRAPHER: Two minutes are left on the tape, Counsel.
Q. (BY MR. STANSBURY:) And at the bottom it says, could you read that note at the bottom? I think it is in your handwriting.
A. "7-18. P.C. - told he committed suicide several days ago (from Dr. Black)."
Q. Now, Dr. Whitehouse, nowhere in here do you talk about emphysema, do you?
A. No.
Q. Okay. Nowhere in here do you talk about any lingering affects from his previous heart surgery, do you?
A. No.
Q. Okay. Nowhere in here do you talk about the loosening of the sternal wires, do you?
A. Yes, I do.
Q. Where?
A. "Except for the sternal click."
Q. Okay.
A. "Disruption of his sternum."

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Q. Let me make sure I understand your language. That means the stern click, disruption of the sternum, that means loose sternal wires?
A. That means he disrupted his sternum at the time of his surgery, yes.
Q. So, we have an individual who Dr. Becker in 1999 read a CT as being negative with respect to pleural changes but having emphysema, showing prior evidence of heart surgery, this person has a diagnosis of ischemia which causes shortness of breath and chest pain, and yet you are focusing entirely upon the progression of his asbestosis, is that correct?
A. I'll give you an explanation for all of this, because I don't think you understand this.
To begin with, he had a bypass. I had a bypass also. I had a bypass 10 years ago. I'm not short of breath. I don't have ischemia anymore. I don't have chest pain. That's very common.
You get a bypass so that you correct whatever vessel it was. And I don't know how many graphs he had at the time.
But he had a good result from that. He had a sternum that clicks and it's an irritant, doesn't affect anything else.
Q. Do you have loose sternal wires, sir?

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MR. HEBERLING: Objection. He may not have finished his answer.
THE WITNESS: I'm not finished yet. I don't have loose sternal wires.
But it doesn't make any difference. I have dealt with these for years. I have set up the whole respiratory unit for the cardiac surgery program at Sacred Heart, which is probably where he had his surgery.
MR. SCHIAVONI: I don't think there is a question pending, so I would object.
MR. HEBERLING: He is finishing his answer.
MR. SCHIAVONI: There is not a question.
THE WITNESS: No. But he is trying to impeach me, and I have the right to say something about it.
MR. SCHIAVONI: No. You can answer whatever questions your lawyer asks when it's his time to ask. But I don't think you can just make speeches.
MR. HEBERLING: There is a question pending, and we can have it read back, if you want.
Q. (BY MR. STANSBURY:) Dr. Whitehouse --
MR. HEBERLING: Wait a minute. He's not finished. We agreed that you would let him finish his answers.

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MR. STANSBURY: I will respect the agreement.
MR. SCHIAVONI: All right. I'm just going to object to form, that this is not an answer, it's just a speech.
MR. STANSBURY: Duly noted.
MR. SCHIAVONI: There is no question pending, and I move to strike.
MR. HEBERLING: Go right ahead and finish.
THE WITNESS: I lost my strain of thought a little bit, too, here on top of it.
He had no evidence that any of this problem with his heart was causing his problem.
Q. (BY MR. STANSBURY:) Okay. This is --
A. His pulmonary function abnormality, if he drops to 84 percent with walking, that's a significant degree of hypoxemia. We don't just normally see that with somebody that's got ischemia or may have had a bypass. That was due to his asbestos disease.
I don't know what Becker read there. I'll show you the x-rays, I'll show you the asbestos disease and the interstitial disease.
And that's a good example. Why would I tell him that Dr. Becker read it as abnormal when he's got all

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of these symptoms, he's got abnormalities, he's got rales, and the bilateral rales are consistent with this asbestos disease.
Q. He didn't read it as abnormal. He read it as normal with respect to asbestos changes. He found --
A. No.
Q. -- emphysema.
THE VIDEOGRAPHER: I'm sorry. I'm going to have to interrupt, or we're going to lose the tape. So, we're going to have to go off the record.
MR. STANSBURY: All right. We will go off the record for five minutes, and we will resume then. Stop the time.
Ken, what's the time?
THE VIDEOGRAPHER: We're going to go off the record. The time is approximately 10:19.
MR. STANSBURY: Okay.
(Short recess).
THE VIDEOGRAPHER: This is tape number 2 of the deposition of Dr. Alan C. Whitehouse. The date is March 19, 2009. The time is approximately 10:32. We are now back on the record.
Q. (BY MR. STANSBURY:) Now, Dr. Whitehouse, you had requested the x-ray or the CT of Raymond Siefke. I would also like to get a copy, or an original of the

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digital versions, to the extent they exist, on CT, of the x-rays or the CT's.
Would you be willing to produce any x-rays or CT's for Raymond Siefke in your possession or CARD clinic's possession?
MR. HEBERLING: There is a procedure for that. Please send us your request.
MR. STANSBURY: We have requested them.
THE WITNESS: You know, I go up there once a month now.
Q. (BY MR. STANSBURY:) Okay.
A. And I've got other things to do besides provide them. If you need those, you can actually make copies of them. They were up there making copies, what, a couple weeks ago of everything that they didn't have.
I think you probably already have copies. Nobody's trying to keep anything from you over there.
Q. We specifically requested his radiology, and none was available.
And, so, what I would ask, to the extent that you have them elsewhere, other than CARD --
A. I don't have them elsewhere. All of my x-rays are at the CARD Clinic. I brought them all up there. So, if they've lost them or whatever the case may be, there is nothing that I can do about that.

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Q. Okay. So, if it's not at the CARD Clinic, you wouldn't have it anywhere else?
A. No. I don't have it at home, or anything like that.
Q. Okay.
A. I don't keep any x-rays at home. And it's possible they might be at the other, the rest of the pulmonary guys might still have it. But I doubt it. Because they've culled everything.
Well, that's been seven years. It might be there. If you can't find it, you'll have to let me know, and I will ask them.
Q. Okay. I am handing you what's been marked as Exhibit 16. This is a March 15th, 1995 record by a cardiologist, Dr. Guy Katz.
A. Uh-huh.
Q. And this is a patient record for Raymond Siefke. And under impression, number 3, "COPD with exacerbation of wheezing."
What is COPD?
A. COPD may be related to emphysema, it may be related to -- it basically is obstructive airways disease. That is what the abbreviation is for.
Q. Could you say the abbreviation out for me, what it is, what COPD stands for?

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A. Chronic obstructive pulmonary disease.
MR. STANSBURY: Did you get that, sir?
COURT REPORTER: Uh-huh.
Q. (BY MR. STANSBURY:) Can COPD be cured?
A. No.
Q. So, if somebody is diagnosed with COPD, they have COPD, correct?
A. No.
Q. Let me rephrase that. If somebody has COPD, they will have it for life, it is not something that can go away over time, correct?
A. No. That's true. If they actually have it.
Q. Okay. Do you doubt whether he actually had COPD?
A. I don't have the rest of the records here. But I know that, from looking at death charts in Libby, a large percentage of the people that die with asbestos disease are called COPD, when there is absolutely no evidence of it whatsoever in the chart.
It is sort of a common nomenclature of family docs and general physicians, that anything that anybody that has trouble with their breathing, they call it COPD.
So, I don't know. You know, you haven't given me the rest of the chart or the pulmonary functions. And I know you've got them.

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Q. Okay. But sitting here today, are you aware of any histological confirmation of Raymond Siefke's asbestosis?
A. I'm not aware of any.
Q. Okay. Do you know if an autopsy was performed?
A. I don't think it was. But I don't know that. It might have been, that I don't know about.
Q. Okay. So, sitting here today, you're not aware of whether there was any confirmation by histology, correct?
A. Correct.
Q. Histology could determine whether he actually had asbestosis, correct?
A. Oh, it could, sure. Possibly.
Q. Okay.
A. Possibly it could, and possibly it might not either. It depends on where they look. Because sometimes they do very limited autopsies.
Q. Who is "they"?
A. Well, in Libby, the mortician has been trained, and I don't think he was trained at this time, so there probably wasn't an autopsy, he's been trained by Brad to take lung sampling.
Q. So, Brad Black, who is a pediatrician,

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trained the -- is he a coroner, or what was his position?
A. You know, you say that in a way, he's pediatrician, like, you know, it's something inappropriate.
No. What he did was he went down and talked to the fellow by the name of Schackenberg (phonetic spelling) about how you can get -- how you sample lungs, which is very easy to do, but you have to do it in six quadrants and things like that in order to get adequate sampling.
And we have a lot of people that already have given permission, their families have, for autopsies when they die with asbestos disease. So -- But I don't think he had been trained in 2002 to do that, I don't think he had gotten that far at that point.
Q. What kind of experience with autopsies does Dr. Black have to permit him to train another as to how to sample lungs?
A. You know, you missed the point again. Okay? The point is, he just showed him where to get six quadrants of tissue out of the lungs and put them in Form 1. That's all he has to do.
It's no big deal. Anybody can do it. You could probably train a chimpanzee to do it.
Q. But they usually have a pathologist to do it,

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correct? Isn't a pathologist usually the person who would determine whether there was any asbestosis, based on histology?
A. He might. But autopsies are very rarely done, because the clinicians generally have far more information about it than actually comes out from the autopsy, which is strictly the anatomic part of it.
The physician, the practicing physician, has the physiology.
Q. So, a chimpanzee could do this?
A. Well, that was maybe a bad crack. But it doesn't require anybody very intelligent to get pieces of lung in the process of embalming a body.
Q. Okay.
A. It's very easy to do.
Q. And then examining that lung?
A. Well, that's up to a pathologist to do it, if they were going to do it.
Q. So, it is certainly not a chimpanzee that would do that part?
A. No.
Q. It would be a pathologist that would examine the lung?
A. That's correct.
Q. And if someone were to examine Raymond

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Siefke's lung and pleura, he or she could have determined whether he had asbestosis, correct?
A. Probably so.
MR. HEBERLING: Objection, asked and answered.
Q. (BY MR. STANSBURY:) Your answer was "probably so," sir?
A. Probably so. But I don't know. It depends on who did it, how much they knew about it.
It's frequent that when you look at the lung, you cannot make a diagnosis of asbestos bodies or see asbestos in the lung. That's not unusual at all.
The same thing with the pleura. In fact, more frequently in the pleura. It's more by visualizing it than it is anything else.
Q. What about Dr. Sam Hammar. Does he have the competence to make that examination?
A. Sure, he does.
Q. What about Dr. Victor Roggli?
A. Roggli?
Q. Yes, sir.
A. I would think so.
Q. I want to shift gears for a second to another issue.
You know, I was in Missoula when you

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testified in the criminal case, and you talked about the fact that your views on pleural disease had changed over time.
Is that correct?
A. That's correct.
Q. Additionally, you were not aware that there was an environmental-only disease in Libby until mid to the late '90s, is that correct?
A. Yes.
Q. Through your work as a pulmonologist, treating people from Libby, and taking occupational histories, you've familiarized yourself with, to an extent, the history of vermiculite operation in Libby, correct?
A. To some degree, yes.
Q. Okay. You are aware of when it began?
A. Yes.
Q. When did it begin?
A. In the 1920s.
Q. Okay. And it continued to the '30s and '40s and '50s, correct?
A. Yes.
Q. What were the exposures like at that time?
A. I assume they were quite high.
Q. Okay. Very high, correct?

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A. Yeah.
Q. And into the '60s, they were also high, correct?
MR. HEBERLING: Objection. Unclear as to where these exposures are.
Q. (BY MR. STANSBURY:) So, Dr. Whitehouse, let's talk about the dry mill, for example. Exposures in the dry mill in the '60s were very high, correct?
A. They were.
Q. And it was in the '70s that the wet mill was put in place, correct?
A. Right.
Q. And the exposures in the wet mill were far lower than the exposures in the dry mill, correct?
A. I assume so, although I don't know that I've seen all the data.
Q. I'm handing you what has been marked as Exhibit 21.
Do you recognize this document?
A. Oh, yes.
Q. What is this document?
A. An article by Amandus.
Q. Okay. Who is Harlan Amandus?
A. Oh, he's somebody that works at NIOSH. He's a Ph.D.

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Q. Okay. And are you aware that he did a study of the Libby workers in the 1980s?
A. Yes.
Q. You're very familiar with this?
A. The '80s or the '70s?
Q. I believe he did a study in the '80s. I believe it was published -- This article, Exhibit 21, which is entitled "The Morbidity and Mortality of Vermiculite Miners and Millers Exposed to Tremolite-Actinolite: Part I, Exposure Estimates," was published in the American Journal of Industrial Medicine in 1987, is that correct?
A. That's right.
Q. And just so I am clear, the American Journal of Industrial Medicine, that's where your 2004 article was published, is that correct?
A. That's correct.
Q. Along with your 2008 case report on mesothelioma cases, is that right?
A. Right.
Q. I have often heard that journal referenced in the same sentence as Dr. Selikoff. Is there a reason for that?
A. Well, Landrigan was the editor of the American Journal who actually took over for Selikoff when

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he died.
Q. So, Selikoff was the editor of this journal until he died?
A. I think he was.
Q. I think he was, too. But if you will turn to page 4.
(Pause in the proceedings).
A. Uh-huh.
Q. Okay. This is a table, Table III, "The Average f/cc," which I believe is fibers per cubic centimeter, is that correct?
A. Uh-huh.
Q. The average --
A. Yes.
Q. Good. "The average f/cc Values Calculated From Membrane Filter Samples Collected in 1967 through 1982 by Location-Operation and Year."
And, so, what we have here is a table that lists, you know, various exposure levels. And I'm not looking to get too far in the weeds here. I just want to establish a couple things. If we look down to dry mill.
A. Yes.
Q. '67 through '71. What is the average exposure?
A. 35.9.

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Q. And that's --
A. Fibers per cc.
Q. And that's a high exposure, correct?
A. Yes.
Q. Somebody who was exposed to that day in and day out for many years could develop asbestosis, correct?
A. And did.
Q. So, that -- Okay. Let's go down to the new wet mill (nonmillwright).
A. Right.
Q. And look at the post-1976 exposures. What are the averages there?
A. 2.0.
Q. Post-'76. Not '75 through '76. Post-'76, which is the one below that.
A. Oh. 0.8.
Q. Okay. And how many samples was that based on?
A. 1200.
Q. Okay. So, that's a lot of data, correct, sir?
A. Yes.
Q. Okay. And this is, again, a NIOSH report, correct?
A. Yes.

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Q. Okay. Now, so, the exposures in the dry mill were substantially higher than the post-wet mill exposures, correct?
A. Yes.
Q. And the dry mill was in operation in the '40s and '50s and '60s, correct?
A. That's correct.
Q. So, people were exposed in the 1940s to very high levels of asbestos, correct?
A. Yes.
Q. And in some cases they brought it home, and that asbestos was unfortunately spread to family members, correct?
A. That's correct.
Q. Okay. And people who were exposed at that time, the latency period for these diseases vary, but is 30 years a reasonable -- is 30 years a reasonable estimate of latency?
A. Oh, I think it's less than that.
Q. 20 years?
A. Well, latency is a very difficult thing to establish, because these people, and Grace's own data, shows that a large number of these people had plaques on their x-rays within five years.
Q. So, people who are exposed in the 1950s,

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their course of disease in some cases was beginning by the 1960s, correct?
A. Yes.
Q. And they were going through this continuum we have discussed, correct?
A. Right.
Q. So, if people would have been exposed in the '40s and '50s, developing diseases in the '60s and '70s and '80s, correct?
A. Correct.
Q. However, and you had the opportunity to treat many of these people, correct?
A. Probably a fair number of them. Most of the ones that I treated had started working there after 1960.
Q. Okay. But even those people who started working, let's say, in 1960 --
A. Uh-huh.
Q. -- the potential that this continuum, as you call it, could have begun in 1965, correct?
A. Could have.
Q. Okay. And then the progression occurs from the onset of disease, correct?
A. Yes.
Q. However, these individuals whom you started seeing in the 1970, 1980, which one?

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A. 1980s.
Q. Okay. So, these people that had been progressing from 1960s who you treated in the 1980s, you never attributed their obstructive disease to their asbestos exposure, did you?
A. Now, what time frame are you talking about? And specifically? We need to be more specific.
Q. I will be very specific. My question deals with people who are exposed in the '50s and '60s.
A. Yes.
Q. Began progressing soon thereafter, and you said as soon as five years.
A. Uh-huh.
Q. And you began treating them in the early 1980s, correct?
A. Right.
Q. But you did not observe a distinct pleural pattern at that time, did you?
A. No. That was a matter of learning it, as time went by.
Q. Okay.
A. In fact there's people, and you probably have got the films, too, that I read as normal in 1980, and then I went back when I saw them in '85 and saw that I missed the findings on it.

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Q. Okay. So, it took you the course of your career to identify the distinct pattern of pleural disease in Libby, correct?
A. No, not the course of my career. No. I identified it within about three or four years of starting to see those people.
Q. So, mid 1980s?
A. Probably.
Q. So, by the --
A. Certainly by the mid-1980s I recognized that there was significant pleural disease. You know, I don't keep track of the dates and that sort of thing.
Q. Let me make sure I'm clear when I say pleural disease. The idea that the pleural disease in Libby was more severe than, say, chrysotile or other forms of pleural disease, you didn't have that opinion in the 1980s, did you?
A. Oh, yeah, I did. I did by the end of the 1980s, yeah. By 1990 I surely did.
Q. You testified earlier, however, that it was the late 1990s, I believe, at the criminal trial, it was in the late 1990s when you started believing that pleural disease in Libby was discussed.
A. No. That was then a misstatement, because I had known before that that the pleural disease was a

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different process.
But it was all in miners at that point in time. It was when the environmental cases and the family member cases started to become so prolific, that I started to look at it more critically.
I don't remember the exact dates. It might have been the early '90s for all I know.
But I know that I saw -- I testified at trial in 1989 relative to pleural disease at that point in time, and I was certainly becoming aware of the fact that there was something different going on.
Q. Now, you mentioned environmental cases. Were people being exposed to asbestos environmentally in the 1950s?
A. Probably.
Q. Okay. Yet you did not see any of these cases until the late 1990s?
A. You know, I don't have explanations for all of that. I don't know the answer to that.
Q. Okay.
A. There is no way I can get the answer to it.
Q. That was my question, was why you weren't seeing this environmental --
A. I have no idea.
Q. -- disease earlier.

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A. I have no idea. Maybe they moved away. A lot of those people died and they were signed out on their death certificates a COPD. We know that. But I don't know the answer to that.
Q. Okay. Now, who is Aubrey Miller?
A. He's a gentleman who worked for the EPA.
Q. And who is Dan Middleton?
A. He's a gentleman that works for ATSDR.
Q. And what is ATSDR?
A. What is it? It's toxic disease registry. What are the first two?
Q. I think it's the agency for --
A. Agency for toxic disease.
Q. Just so we have it clear.
A. Right.
Q. Agency for Toxic Substances and Disease Registry, is that correct?
A. That's right. You've got it.
Q. And you are aware of the mortality analysis that they did for 1979 to 1998, is that correct?
A. Yes.
Q. What is your opinion of that study?
A. It's a very flawed study.
Q. Why is it flawed?
A. Well, if you show me the --

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Q. Sure.
A. -- the chart in there.
Q. Yeah. I'll give it to you right now.
A. Where is mine?
Q. Here is your copy right here.
A. You've got mine.
Q. Sure. Sure. I'll give this back to you. No. I will hand you what has been marked as Exhibit 25, which is mortality in Libby, Montana, 1979 to 1998.
A. Right.
(Pause in the proceedings).
MR. HEBERLING: Does that have an Exhibit Number?
MR. STANSBURY: 25.
THE WITNESS: It's got the whole thing in here. I will see where the one page I want is.
Q. (BY MR. STANSBURY:) Okay. You go to the page you want and I'll go to the pages I want.
A. Well, go ahead.
Q. Can you flip back, there are some tables in the --
A. It's on page 25, is probably what you're going to want me to look at.
Q. All right. Well, Table 8.
A. Yep.

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Q. So, are you familiar with this table?
A. Oh, I'm very familiar with it, yes.
Q. Now, are you familiar with confidence intervals?
A. Yeah. And to begin with, it's a very flawed study. They have one case of asbestosis.
And this was a death certificate study. That's all. They didn't look at charts or anything else.
Q. Okay. I understand, sir.
A. And the doctors in Libby signed everybody out as COPD. I mean, it's garbage in, garbage out.
Q. Let's look at that COPD line within Table 8.
A. I know that. I know that.
Q. And against the Montana SMR and U.S.SMR, and in both incidents the confidence intervals include a range of a value of less than 1, is that correct? Is that correct?
A. You know, I'll stick to what I said. It's garbage in, garbage out.
Q. Dr. Whitehouse, is that correct, though?
A. Yes. For what it says, yeah, what it says there. But it's garbage.
Q. It's garbage because they only looked at death certificates?
A. Yeah. And the way the death certificates

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were coded, which was mostly COPD. And I've looked at those, and they are the same death certificates, and have the charts.
Q. And based on that notion, that they are mostly COPD, we should probably see some of the asbestosis deaths classified as COPD, then, correct?
A. A huge number of them.
Q. Right. So we have 73 observed COPD deaths. Is that correct?
A. Yes.
Q. In the Montana expected was 86.1, is that correct?
A. Yes.
Q. The U.S. expected was 63.2, is that correct?
A. That's what it says.
Q. Now, the confidence intervals for the SMR's for both include a value of less than one, correct?
A. Yes.
Q. Okay. So, that suggests that there is no statistically significant elevation in COP death rate within the nonworking population in Libby from 1979 to 1998, correct?
A. No.
Q. Why?
A. Because the study is so badly flawed that it

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should not have ever been published in here.
Q. You said it was badly flawed in part because they were sticking asbestos --
A. No. Because all they did was death certificates.
Q. Let me finish my question, please.
A. Okay.
Q. You said part of the flaw -- the big flaw of this study was that asbestosis deaths were improperly classified as COPD.
Now, if that were the case, we should see an elevated level of COPD deaths, were there elevated deaths of either asbestosis or COPD in the non-working population, correct?
MR. HEBERLING: Objection, misstates the testimony. He didn't say that was the big flaw.
THE WITNESS: This study was done on death certificates only. Charts weren't reviewed.
And you don't do studies concerning mortality of diseases like this without having looked at the charts.
Because if you rely on physicians who are not even aware of the problems that they've got in the community to code death certificates, they code most of them as COPD, or other respiratory things, you know, and

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then there's the combined cause, and God knows what that is. I know very well that it's flawed.
Q. Dr. Whitehouse, I'm going to repeat the same question. I don't think you answered it last time.
If they were misclassifying asbestosis deaths as COPD, the deaths still would have showed up as COPD deaths, correct?
A. Yes. But maybe the COPD rate was lower. I don't know. You know, you are asking me to answer a question, a hypothetical question, based upon crummy data, and I'm not going to answer it anymore because there is no way to do it.
Q. This is not a hypothetical question, Dr. Whitehouse. You are the person who has introduced the possibility of misclassification of asbestosis death as COPD.
You do agree that that happens, correct?
A. Yes.
Q. Okay. And if that happened, we would then look at the COPD deaths to see if there was an elevated level of COPD, correct?
MR. HEBERLING: Objection, asked and answered.
Q. (BY MR. STANSBURY:) We are not seeing that, are we?

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A. No. Maybe because of being in Libby and maybe, these were environmental, excluding workers and all, maybe they were nonsmokers. Maybe the COPD death rate might have been very, very low.
Maybe 40 of those deaths are all asbestosis deaths that were miscoded, then the COPD death rate is lower. I don't know the answer to that. I know the study was badly flawed.
You mean, only one death from asbestosis? That's ridiculous. I had a half a dozen in my own practice.
Q. From environmental exposure?
A. Yeah. Not from environmental. I guess, it excludes workers.
Q. Right. That's the whole point of this, Dr. Whitehouse. I'm looking at environmental only. I'm excluding the working population.
And I heard your earlier criticism that they misclassified asbestosis as COPD. And I wanted to look at that a little bit more closely. However, I am not seeing a statistically elevated level of COPD, nor am I seeing a significantly elevated level of combined causes of death either. Which combines lung cancer, mesothelioma, COPD, asbestosis and other respiratory diseases.

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Am I reading that correctly, combined causes?
MR. HEBERLING: Objection, asked and answered. He said it was crummy data. That's it.
MR. STANSBURY: I'm going to ask you to no longer direct the witness. You can lodge your objection, but they should be stated succinctly and not in a manner to try to steer the witness. Thank you.
Q. Dr. Whitehouse, combined causes looks at other respiratory, asbestosis, COPD, mesothelioma and lung cancer, correct?
A. Yes.
Q. And there is not a statistically significant elevated level of death by those combined causes amongst the non-working population in Libby from 1979 to 1998, correct?
MR. HEBERLING: Objection, asked and answered.
THE WITNESS: It's crummy data, and I'm unable to deal with it anymore.
Q. (BY MR. STANSBURY:) Dr. Whitehouse --
A. I know it's crummy data.
Q. Dr. Whitehouse?
A. Yes.
Q. I'm just asking what the table says and whether it's accurate. This is from the ATSDR, who you

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have dealt with, working with on your pilot study. This is a government agency. And I am asking about what they find based upon a review of death certificates.
MR. HEBERLING: Objection, asked and answered. You're asking again if he thinks it's accurate. He's answered that --
Q. (BY MR. STANSBURY:) Dr. --
MR. HEBERLING: -- three or four times.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, I'm not asking you for anything other than what the table says. And by combined causes of death, we see no statistically significant elevated level of death in the non-working population from 1979 to 1998, correct?
MR. HEBERLING: Objection, asked and answered.
Q. (BY MR. STANSBURY:) Correct, sir?
MR. HEBERLING: Objection. Asked and answered.
Q. (BY MR. STANSBURY:) Correct, sir?
MR. HEBERLING: Objection, asked and answered.
Q. (BY MR. STANSBURY:) You may answer the question.
A. In reviewing very flawed deaths -- very flawed data, that's what it says.

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Q. Okay. We have come to agreement on that, then. You do not agree.
What analysis have you done to determine that the data was flawed?
A. You know, I haven't done an analysis myself. But I'm very tuned to what goes on in Libby and what is said about this by a variety of people.
And I'm not even going to try to repeat or go through everything. But I've been known -- I've known for a long time that this was flawed data.
Q. Let me unpack what you've just said. You haven't reviewed this data systematically to analyze whether it's --
A. No.
Q. -- valid, correct?
A. No. That information came from people that were in the know about the study and how it was done in the first place.
Q. Who were these people in the know?
A. I don't know. I can't even remember who it was, it's been so darn long ago. This came about in meetings and things like that that I have been to.
Q. But just so I am clear, you haven't analyzed this data yourself, then?
A. No, I haven't. Why would I?

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Q. Well, because you are sitting here, trying to not answer a question, based on --
MR. HEBERLING: Objection, argumentative.
MR. SCHIAVONI: I would move on.
MR. STANSBURY: May I finish the question?
MR. HEBERLING: No. You can't finish a question like that.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, you have criticized this data and are refusing to answer questions about the data in this study, but you yourself have not analyzed this data, have you?
MR. HEBERLING: Objection, argumentative. He has not refused to answer your questions. Ask him a proper question.
Don't answer that question.
MR. STANSBURY: Dr. -- Excuse me. Mr. Heberling --
MR. HEBERLING: Go ask a proper question.
MR. STANSBURY: -- please do not instruct your witness.
THE WITNESS: He has instructed me not to answer the question. I am not going to answer.
Q. (BY MR. STANSBURY:) Is he your lawyer?
A. What?

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Q. Does he represent you?
A. He represents the Libby people.
Q. Okay. I am asking you a question. You are not answering questions about --
Did you refuse to answer any more questions about this?
A. No, not about the other. But I am not going to answer that question.
Q. About the table?
A. Yeah. You are going to ask me whether or not I reviewed the data myself.
No, I didn't review the data myself. You already know the answer to that.
Q. Okay. Good. I just wanted to make sure we are clear on that.
A. So, why ask?
Q. Because you were refusing to answer other questions --
MR. HEBERLING: Objection. He has not refused. The record will show that he has not refused to answer other questions.
MR. STANSBURY: Allow me to state my questions before stating your objections.
MR. HEBERLING: It's not a proper question.

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Q. (BY MR. STANSBURY:) Dr. Whitehouse, you didn't want to answer any more questions about Table 8, did you? And because, the reason you stated was, you didn't like the data in this study, correct? Garbage in, garbage out?
A. That's correct.
Q. Okay. Garbage in, garbage out, but you never analyzed the data yourself, did you?
A. I did not.
Q. Okay. Thank you. I'm handing you what's been marked as Exhibit 26. And this is entitled Review of Asbestos-Related Abnormalities Among a Group of Patients from Libby, Montana, A Pilot Study of Environmental Cases, Final Report, August 2002.
A. I'm aware of this.
Q. Okay. And in fact you weren't just aware of this, you were involved in this, weren't you, sir?
A. Yeah. I provided the cases.
Q. And you worked with Dan Middleton on this, correct?
A. Well, basically, I provided the cases that I thought were environmental cases.
Q. Okay.
A. And then they took it from there.
Q. Okay. Did you have any involvement with them

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after they took it from there, as you put it?
A. No.
Q. Okay.
A. None at all.
Q. I hand you what has been marked as Exhibit 27. It is a letter dated March 21st, 2001, from you to Jon Heberling, attorney.
And that is Jon Heberling sitting next to you, correct?
A. Uh-huh.
Q. Yes, sir?
A. Yes.
Q. And focusing on the second -- third paragraph, "The second issue that came up concerning," and this name has been redacted, "is that the EPA has asked me about patients I might have that have asbestos only from insulation and having worked outside of Libby. I guess this is of some importance to them as far as their getting funds for their continuing investigation. I would wonder how you feel about releasing data on a confidential basis to the EPA concerning" blank. "It would be all right with" blank "to do so but I thought I would check with you first."
Do you remember writing this letter, sir?
A. No.

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Q. Okay. Is that your signature at the bottom, sir?
A. Yes.
Q. Okay. Now, is this in any way related to the ATSDR pilot study?
A. No, I don't think so.
Q. Okay. This is about providing materials to EPA.
A. Yes.
Q. Was there ever a study that came from this?
A. I don't think so.
Q. Did you provide any information to EPA?
A. I don't know. I don't think so. I doubt I did.
Q. Okay.
A. But I don't know.
Q. Why would you be seeking Jon Heberling's permission to send patient records, your patients, to EPA?
MR. HEBERLING: Objection, misstates the letter. It doesn't necessarily mean patient records.
THE WITNESS: I'm not even -- I don't even recall what this was about.
(Pause in the proceedings).
THE WITNESS: I have no idea. I can't

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even recall.
Q. (BY MR. STANSBURY:) Okay. Well, I'm handing you what has been marked as Exhibit 28. This is a deposition of Dan Middleton, taken in the cost recovery action.
You mentioned that Dan Middleton was one of the individuals you had worked with on the ATSDR pilot study. You provided him with cases, correct?
A. Yeah.
Q. Okay. I'd like to direct you to page 13 of his sworn testimony. And if you look right here where my finger is pointing, which doesn't have line numbers, but about a fourth of the way down the page.
"QUESTION: When you made this request of Dr. Whitehouse, how many people did he identify?
"ANSWER: 27.
"QUESTION: 27? At any time did he tell you there were more than 27?
"ANSWER: I think that there was a cutoff point. I think that he gave us -- I would have to go back to the protocol, but I believe there were up through -- well, I don't remember exactly what it was to be honest with you, but it was sometime between when we started in 2000 and the report. But, there was a cutoff point and he did indicate that there were more, but I

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believe he identified he had seen up to a certain point.
"QUESTION: Certain point in time?
"ANSWER: Yes.
"QUESTION: But you believe that he told you that there were actually more than 27?
"ANSWER: Yes.
"QUESTION: And what did you do with that information that there were more than 27, did you want to get that information?
"ANSWER: We didn't pursue that. We had to have some cutoff point, so we selected a cutoff point."
Did I read that correctly, sir?
A. Yes.
Q. So, you had more than 27, but you only provided 27 to ATSDR, is that correct?
A. I provided all I had up to the cut-off point that they gave me.
Q. Okay.
A. And I don't know how many more I had after that.
Q. And how many of those individuals were determined to have only environmental exposure?
A. In that 27?
Q. Yes, sir.

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A. There were eight of them.
Q. So, out of the 27, eight had environmental exposure, correct?
A. Yeah. And basically what they did was they went through every little single detail about it, and were able to find another exposure, and they were very, very strict about the thing, to get down to those eight.
Q. Okay. I'm going to ask you to turn to page 18, please. Now, these x-rays for these individuals were classified by B-readers, correct?
A. I think they were, yeah.
Q. Three B-readers, actually, right? I'm going to read, and please follow along with me toward the top of the page.
"QUESTION: With respect to these four that the reviewers and your study had found did not have lung changes consistent with asbestos-related disease, how did Dr. Whitehouse react to that?
"ANSWER: He was upset.
"QUESTION: Did he tell you why he was upset?
"ANSWER: I don't think so.
"QUESTION: How did he express that state of being upset, did he call you?
"ANSWER: Yes.

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"QUESTION: And --
"ANSWER: Yes. He did call me at least once to discuss it.
"QUESTION: And can you" --
Answer, they're talking over each other.
"ANSWER: Well, I can't recall if I called him or he called me but we talked.
"QUESTION: You had a conversation.
"ANSWER: Yes.
"QUESTION: What was the nature of what -- what did he express to you about these findings?
"ANSWER: He was very upset that the B-readers had not confirmed his reading of x-rays.
"QUESTION: And did he give you any opinion? What did he tell you about the B-readers results? What did he say about it?
"ANSWER: I don't remember specifically. He was upset that they had disagreed with him and certainly believed he was correct.
"QUESTION: Did he ask you to redo the study with respect to those people?
"ANSWER: I think he -- not redo the study, I think he was -- his first question -- what we do is a case series and he asked if we could just leave those out.

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"QUESTION: And you didn't leave them out, though, right?
"ANSWER: No.
"QUESTION: Why not?
"ANSWER: It wouldn't have been a complete -- it would have been inappropriate."
Did I read that correctly, sir?
A. Yes.
Q. Do you recall this conversation of Mr. Middleton?
A. I don't recall that conversation. And I want to go down about another line, too.
Q. Okay. Sure.
A. "QUESTION: Did he ever threaten to take his name off your poster?
"ANSWER: Yes."
Q. Answer, yes. Okay. So, you were upset and you threatened to take the name off the poster, is that true?
A. No.
Q. You never threatened --
A. No. That's an absolute wrong.
Q. So, you do not agree with what Mr. Middleton has said under oath?
A. No. I never talked to him about that at all.

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I never would have said that. You know --
Q. Did you have a reaction --
A. I didn't have this reaction about being upset either. I called him -- or he called me, one or the other, to talk it over with him about what the B-readers --
These were people, some of whom had fairly subtle findings on their x-rays that I, you know, that I gave him the names to. Perhaps maybe what we need to do is go back and get all of those names out of there and then go back and look at the x-rays again and see what happened subsequently to them.
Q. That would be great.
A. Get the whole charts.
Q. That would be great. If I requested that through Mr. Heberling, would you be willing to give me the names of the individuals who were in the ATSDR pilot study?
A. I don't even have them anymore.
Q. You don't have them anymore?
A. I don't. Dan Middleton has them. It was all confidential. He has the names, though, at this point.
Q. Okay.
A. Or he has the numbers that would allow it to be found. It was a long time ago.

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Q. Okay. Okay. I'm handing you what's been marked as Exhibit 30.
First let me ask you, do you know who Bruce Case is?
A. Oh, yes.
Q. Who is Bruce Case?
A. He is an investigator at McGill, I think.
Q. I'm handing you what's been marked as Exhibit 30, and it says, Libby Claimants' Disclosure of Potential Expert Witnesses, and at the bottom first page, Bruce Winston Case, M.D., M.Sc, Dipl. Occ. Hyg., F.R.C.P.(C.), and he is at the Department of Pathology, Montreal General Hospital.
Now, I understand that this individual is no longer an expert witness for the Libby claimants. But it appears that he was initially named as one. And if you look on the next page, so was Arthur Frank and yourself.
Were you aware that Bruce Case was potentially an expert witness on behalf of the Libby claimants?
A. At one time I do remember that, yes.
Q. Do you remember why he was no longer included as an expert witness?
A. I think actually it was because of the fact that he felt that chrysotile was not a toxic substance,

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and that -- You laugh, but that is exactly what he thought.
Q. I spilled something on myself. That's why I laughed.
A. But he had been writing about it and various things, had been testifying on behalf of the Canadian government. And it just felt pretty inappropriate to use him.
Q. Okay. So, his opinions on the toxicity --
A. I don't know anything about him, to tell you the truth, other than that. That's about the total extent of my knowledge.
Q. Were you aware that he did a review of the ATSDR pilot study?
A. No.
Q. Okay. I'm going to hand you what has been marked as Exhibit 31. And this is a letter to Donna Rossie, ATSDR, from Bruce Case, and it is a "Review of the Asbestos-Related Abnormalities Among a Group of Patients from Libby, Montana: A Pilot Study of Environmental Cases."
And most specifically, I want to direct you to page 3, please.
(Pause in the proceedings).
A. Page 3?

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Q. Yes, sir. The page number at the bottom of page 3 --
A. There is no number.
Q. Is there a Bates number on the far right?
A. Yeah.
Q. Okay. If you look at 2009_05840.
MR. HEBERLING: I'll object. I think you're asking the witness to comment on a document that you haven't established that he's ever seen before.
Q. (BY MR. STANSBURY:) Have you ever seen this document before?
A. I've never seen it before. I have no idea what it is.
Q. Okay. I'm going to read from the second paragraph. Tell me if I read there correctly, please. "The term 'disease' is misapplied, or perhaps just inadequately explained, to" --
A. Where are you?
Q. Oh. I'm sorry. I am in the second to last paragraph, the first sentence, "The term disease."
A. Yes.
Q. "The term 'disease' is misapplied, or perhaps just inadequately explained, to 'pleural plaques.' Most scientists in this area do not consider pleural plaques a 'disease,' but a marker of exposure. There also seems to

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be an unclear separation in some of the tables between diffuse pleural fibrosis (which is a very serious disease) and pleural plaques."

Did I read that correctly, sir?

A. Uh-huh.

Q. Yes, sir?

A. Yes.

Q. Okay. Do you agree with that statement?

A. No. Because in fact the ATS in their 2004 statement, they finally decided that pleural plaques are a disease.

Q. We will look at that statement in a little bit.

Let's turn to page, I guess it's actually the next page, 2009_05841, first paragraph. "Goals and Objectives: These are clearly enough stated, but suffer from the deficits inherent in the above comments. In addition, even accepting the validity of a search for so-called 'environmental' disease as a separate category, the authors fail to verify whether or not their subjects actually had exposure at the vermiculite mine."

Do you agree with that statement?

MR. HEBERLING: Objection. This is a document he said he's never seen before.

(Pause in the proceedings).

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THE WITNESS: "Exposure at the vermiculite mine." These are environmental cases.

This study came about because I had a number of cases that appeared to be just environmental exposures, and just people that lived in Libby.

So, they may or may not actually have had exposures to the mine. They probably did not. I didn't think they did at the beginning. Now, maybe they did and I didn't know about it.

That's why the pilot study was done, was to look for that sort of stuff, that's the reason it was done in the first place.

Q. Do you agree with this criticism?

A. No. What's he criticizing, and for what reason?

(Pause in the proceedings).

A. I don't get it. It was a pilot study just to demonstrate that there were a number of cases that truly were environmental.

All the rest of the stuff that you've got here is just all sort of tangential.

That's the whole reason for doing it. That's the reason they came to my office, because they knew that I had said that I had environmental cases, and provided all the x-rays and all the other stuff for them, and then

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they wound up selecting the whole thing.

Q. So, to what --

A. I mean, because that was of something that had not been significantly described previously in Libby. That was the only reason for the pilot study.

Q. You say "they." Are you talking about Aubrey Miller?

A. I'm talking about Aubrey Miller and Dan Middleton. You know, we provided all the films and the charts and things. I got releases from all the patients to do it.

Q. And, so, would you say that your conversation with them is what really informed them on the potential of environmental disease?

A. Would you repeat that?

Q. Was your conversation with them what informed them about the potential for environmental disease?

A. Oh, basically --

MR. HEBERLING: Objection, lack of foundation, hearsay.

Q. (BY MR. STANSBURY:) You can answer, sir.

A. I'm not sure how to answer that. I mean, basically I told them that I thought that there was environmental cases there of pleural disease. Okay?

Q. All right.

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A. And you're saying, well, they didn't have disease. Well, according to the ATS, they do have disease, and at the time I thought they had disease, too.

Q. I'm not saying that. I'm handing you a document by Bruce Case who earlier was named as an expert.

A. This is sort of garbage, too.

Q. Well, look at 2009_05847.

(Pause in the proceedings).

A. Uh-huh.

Q. At the very bottom, "Select the appropriate category below." He indicates that he did not recommend this study. Correct?

A. "Recommended changes or reasons for not recommending." "Not recommended." What does that mean?

(Pause in the proceedings).

Q. You don't understand what he means by "not recommending"?

A. No. I haven't the slightest idea what he means.

Q. Okay.

A. I wish you would explain to me what that question means.

Q. I believe it means that he's not recommending that they publish the study.

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A. It doesn't say that. It says "appropriate category below (list recommended changes or reasons for not recommending)." He just says not recommending -- "Not Recommended."

What does that mean? He didn't recommend any changes. It doesn't say anything about whether to publish it or not.

Q. Okay. Fair enough. Now, we've talked earlier about this continuum disease and we've talked about pleural plaques and we've talked about diffuse pleural thickening.

We haven't talked as much about asbestosis. Now, you've talked about this with individuals before. You believe, if I understand correctly, that pleural changes can be classified as pleural asbestosis, is that correct?

A. That's correct.

Q. And you cite as your basis for this, the work of Dr. Irving Selikoff, correct?

A. Well, part of it. Also, my own observations that it's all part of a continuum. You go from plaque to pleural thickening to interstitial disease.

Q. But in terms of just the origin of the term, that is a Selikoff term, correct?

A. Yeah. But it gets used more and more all the

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time. I see it in the literature all the time now.

Q. I hand you what has been marked as Exhibit 34. And this is entitled "Asbestos, asbestosis, and Cancer: the Helsinki criteria for diagnosis and attribution."

Are you familiar with this consensus report document?

A. I've seen this report, yes.

Q. Have you read it before?

A. A long time ago.

Q. Okay. If you will turn to the second page, 2009_04732. Do you see that?

A. Uh-huh.

Q. And on the second column under "Pleural disorders," are you following me?

A. Uh-huh.

Q. First paragraph, last sentence. Tell me if I read this properly. "Avoidance of the term 'pleural asbestosis' is recommended. Pleural plaques are usually asymptomatic, and without clinically important findings."

Did I read that correctly, sir?

A. Yes.

Q. And this is from the Scandinavian Journal of Organ Environmental Health, 1997, correct?

A. That's correct.

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Q. And that was after Dr. Selikoff's work?

A. Yeah. It says "Pleural plaques are usually asymptomatic, and without clinically important findings."

Well, there's been numerous articles that show that pleural plaques are associated with pulmonary function abnormalities, and they obviously go on and develop it.

You know, basically it's wrong, and the ATS finally recognized that it was wrong. So, regardless of what they put out, it's wrong.

Q. Let's turn to the last page of that document, please.

A. Okay.

Q. 2009_04736.

A. Okay.

Q. On this page if you look at the beginning -- the end of the previous page, you see the list of participants.

A. Yeah. So?

Q. Do you know John Dement, are you familiar with him?

A. Well, where are you on this page?

Q. Top of 2009_04736, top left, first line, John Dement. Do you see that, sir?

A. I'm familiar with the name.

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Q. He used to work at NIOSH, correct?

A. He did.

Q. He was a signatory to this document, wasn't he?

A. He was.

Q. At the bottom of that same column, John E. Parker (National Institute for Occupational Safety and Health, United States)."

Are you familiar with Dr. Parker?

A. Yes.

Q. Who is Dr. Parker?

A. Wait a minute. That's a different Parker. I'm not familiar with him.

Q. Okay. You're familiar with the Amandus study?

A. Right. He is one of the authors on that.

Q. He was not. But are you aware that he was one of the individuals who traveled with Harlan Amandus to explain the findings of the study to the Libby workers?

A. I was not aware of that.

Q. Are you aware that he's also a pulmonologist, such as yourself?

A. There is no way I would be aware of that.

Q. Are you familiar with the Peipins study? I

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believe Dr. Black --
A. I am.
Q. And that was also part of the ATSDR screening study, correct?
A. Yes.
Q. Were you aware that Dr. Parker was the tie breaking B-reader in that study?
A. No, I was not.
Q. You were aware that Dr. Lockey was a reader in that study, correct?
A. Oh. You're talking -- This is not John Parker.
Q. Jack Parker?
A. Jack Parker. Okay. That's who we're talking about now. I know who that is.
Q. So, we're talking about, he goes by John, I guess, in his formal --
A. No. He goes by Jack.
Q. So, we're talking about John or Jack Parker.
A. We're talking about Jack Parker. We all know who Jack Parker is.
Q. So, let me kind of ask you those previous questions then, just under this new understanding.
Were you aware that he travelled with Dr. Amandus to Libby?

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A. No, I was not aware of that.
Q. Okay. You are aware that he was the tie breaking B-reader?
A. Yes.
Q. You are aware that he was a co-author of the ATSDR CT study, correct? The Muravov study?
A. I am not aware of that. I don't remember that for sure.
Q. Okay. Are you aware that he is currently reading x-rays from Libby for ATSDR at this time?
A. I'm not sure whether he's reading them now or not.
Q. You're aware that there's an ongoing ATSDR analysis, correct?
A. Well, we have taken over the Massa study. That is now to my knowledge all being done through the clinic, and they are being sent to Lynch and to Newell. And I don't know that there is other readings.
I have not seen Parker's name on a reading for a long time.
Q. But you are aware that he was a reader in 2000 and 2001?
A. Oh, he was back then, yeah.
Q. Now, nowhere in this document does he carve out Libby from the description of pleural plaques,

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correct?
A. Well, why would he? This is in '97. This is long before the whole business with Libby broke.
Q. Well, he was in --
A. And he wasn't looking -- There would be no reason for him to really do so when they were looking strictly at miners when the Amandus study was done.
Q. But there is no mention by Dr. Parker that, having worked with Dr. Amandus, I see a different experience with respect to pleural disease in Libby?
A. I don't know. I haven't even talked to him. I don't even know what his thoughts are on it. I have no idea.
Q. What about Dr. Victor Roggli?
A. I know who he is.
Q. Okay. I am handing you what is marked as Exhibit 35. And this is "Asbestos-Related Disease Associated with Exposure to Abestiform Tremolite."
A. Uh-huh.
Q. And the authors are Sharon Srebro, S-R-E-B-R-O, and Victor Roggli, R-O-G-G-L-I. And this was published again in the American Journal of Industrial Medicine in 1994, is that correct, sir?
A. That's right.
Q. Are you familiar with this study?

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A. I think I've read it sometime along the line. I don't remember when, though.
Q. But this isn't the first time you've laid eyes on this, correct?
A. No, I don't think so.
Q. And, again, this was before the Helsinki criteria document, correct?
A. Way before.
Q. Well, not way before. Three years. If you would turn to page 2009_08079.
(Pause in the proceedings).
A. All right.
Q. At the top of the page, I guess it's the first full sentence after the Roggli and Longo cite, "The other (case 2) was a man who lived near a vermiculite processing plant during the first 20 years of his life and, as a child, sometimes played in the piles of vermiculite tailings. The longest tremolite fibers detected in this study were in this patient, with many greater than 100 microns in length. Representative scanning electron micrographs from this case are shown in Figure 1."
Did I read that correctly, sir?
A. Yeah.
Q. So, clearly he has familiarity with tremolite

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from vermiculite, correct?
MR. HEBERLING: Objection. Unclear as to who "he" might be.
Q. (BY MR. STANSBURY:) Dr. Roggli. Is that correct, sir?
A. Well, of course -- Okay. You're talking about tremolite. Are you talking about South Carolina, vermiculite processing plant, or are you making the assumption it was Libby?
Because there is indeed two tremolite vermiculite processing plants that W.R. Grace owns in South Carolina to my knowledge. Is that where it came from?
Because, you know, if they are analyzing all of this stuff, they would have found that it wasn't tremolite to begin with.
Q. And if you would turn to page 2009_08077, I believe it is actually two pages earlier than where you are now.
A. Uh-huh.
Q. The paragraph underneath the table, do you see where I am at?
A. Uh-huh.
Q. Yes, sir?
A. I see it.

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Q. I guess it's the second full sentence, "The diagnosis of asbestosis was confirmed by one of the authors using the histologic criteria set forth by the Pneumoconiosis Committee of the College of American Pathologists and the National Institute for Occupational Safety and Health, which defines the minimum criteria permitting the diagnosis of asbestosis as 'demonstration of discrete foci of fibrosis in the wall of respiratory bronchioles associated with accumulations of asbestos bodies.'"
Do I have that correct, sir?
A. Uh-huh.
Q. Yes?
A. Yes.
Q. And the cite is the Craighead?
A. What?
Q. The cite is the Craighead?
A. Yes.
Q. That is defining asbestosis based on interstitial fibrosis, correct?
A. Yeah. Basically, yes.
Q. Not fibrosis of the pleura, correct?
A. Well, all he's talking about right there is defining diagnosis related to foci in the respiratory bronchioles. Yeah. That's fine. That's an okay

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definition for asbestosis. But it doesn't say anything about anything else.
Q. That's right. There's no mention of pleural asbestosis as a means of diagnosing asbestosis, correct?
A. Why would there have to be?
Q. Why would there be if it wasn't asbestosis?
A. Well, you know, I have no idea why he selected that, why he doesn't deal with anything else at the time, except that at that time that was the same time people thought that plaques were not a disease and were pretty much ignoring pleural disease, and were also in this article talking about tremolite and not about what was going on at Libby.
So, I am not quite sure how this fits in.
Q. So, you are not aware of whether that tremolite was from South Carolina or Libby?
A. I have no idea.
Q. But that would be relevant to Dr. Roggli's understanding of disease from tremolite in Libby, correct?
A. It might be. It might not be.
Q. Again, though, Dr. Roggli is signatory of the Helsinki criteria, who at least had experience with asbestosis caused by exposure to tremolite, made no reference in the Helsinki criteria to a different

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criteria for looking at pleural disease in Libby, correct?
A. No.
Q. Okay. I'm handing you what's been marked as Exhibit 36. Do you recognize this document, sir?
(Pause in the proceedings).
A. Well, this is the old ATS one, I take it, isn't it?
Q. Yes, sir. The 1986 ATS statement. And if you could turn to page 2, which is 2009_00054.
A. Uh-huh.
Q. On the far left column, second to last paragraph, under the heading "Pulmonary Asbestosis, Definition." I am going to read, and please tell me if I read this correctly. "The term asbestosis should be reserved for the interstitial fibrosis of the pulmonary parenchyma in which asbestos bodies or fibers may be demonstrated. While pleural abnormalities are commonly associated with parenchymal disease, they should be separately classified as there are differences between pleural and parenchymal fibrosis in epidemiology, clinical features and prognosis."
Did I read that correctly?
A. Yeah. You read it right. Except it has been 18 years until the next ATS study. Clinical thinking has

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changed.
Q. Okay. But as of 1986, the 1986 study, based on the 1986 ATS statement, asbestosis was defined as parenchymal disease, correct?
A. Oh, yes. It had been for years before that.
Q. Okay. And when you were examining people in Libby pre-2004, this was the most authoritative document by the American Thoracic Society on the diagnosis of asbestos disease, correct?
A. Yeah. Although I don't know that I had ever seen that at the time. I was following through with what Selikoff was saying.
Q. So, while you were diagnosing people prior to 2004, you were not following the ATS guidelines for diagnosing asbestos disease?
A. I was using the term asbestosis for both, because it was real clear, and Selikoff backed that up, that you could call it pleural asbestosis, but when you became logical about the whole thing, they were all part of the same spectrum.
Q. So, just so -- I think you said earlier, you weren't familiar with this back then?
A. Oh, I may have seen it a long time ago. I haven't looked at it for years, though, if I have. I'm not sure I ever looked at it. I know what was in it.

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Q. But this document, and the contents of this document, did not guide your diagnostic practices, correct?
A. Not at all.
Q. Okay. I am handing you what has been marked as Exhibit 37. Do you recognize this document?
A. Yeah. This is the 2004 statement.
Q. This is the 2004 American Thoracic Society statement on "Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos."
A. That's right.
Q. Okay. And if you would turn to 2009_00667, and there's two columns. The right column, we have the heading halfway down the page, "Nonmalignant Disease Outcomes," and we have "Asbestosis."
(Pause in the proceedings).
A. Where is this?
Q. Sure. 2009_00667. Are you there, sir?
A. 667. Okay.
Q. Okay. Good. Far right column.
A. Uh-huh.
Q. Halfway down the page. "Nonmalignant Disease Outcomes."
A. Uh-huh.
Q. "Asbestosis." Are you with me?

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A. I've got it.
Q. Second paragraph. Tell me if I have read this correctly. "Asbestosis specifically refers to interstitial fibrosis caused by the deposition of asbestos fibers in the lung. It does not refer to visceral pleural fibrosis, the subpleural extensions of fibrosis into the interlobular septae or lesions of the membranous bronchioles."
Did I read that correctly, sir?
A. You did.
Q. And you recognize this document, the 2004 ATS statement, as being of great value in guiding your diagnostic practice, correct?
A. Well, not of great value. It is like all other documents that are published. It produces guidelines for people, but that's all. I mean, it doesn't really change what you do.
Q. But the American Thoracic Society, this is their authoritative statement as of 2004, correct?
A. Yeah, basically.
Q. And in this statement it says that asbestosis specifically refers to interstitial fibrosis, correct?
A. It also says in here it refers to pleural asbestosis, in another area in here, by the way.
Q. Where? Where does it say pleural asbestosis?

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A. I'm not sure where it is. I would have to find it.
Q. Take a second.
(Pause in the proceedings).
A. Well, it's going to be more than a second.
MR. STANSBURY: We can go off the record. Let's go off the record and take a break. You can look for it. Then we will go back on the record.
THE VIDEOGRAPHER: We are going to go off the record. The time is approximately 11:33.
(Short recess).
THE VIDEOGRAPHER: We are going back on the record. The time is approximately 11:40.
THE WITNESS: I actually can't find that in this article. And I've been reading a bunch of other articles that I know it's in recently. And I suspect that's where I mixed it up.
Q. (BY MR. STANSBURY:) So just so the record is clear, the 2004 ATS statement says "Asbestosis specifically refers to interstitial fibrosis caused by the deposition of asbestos fibers in the lungs," and it does not use the term pleural asbestosis, is that correct, sir?
A. That's correct.
Q. Okay. Let's move on at this time. Well,

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actually, before I do that, it's fair to say, isn't it, that numerous people that you have diagnosed, in whom you have only seen pleural abnormalities, you've called them asbestotic, is that correct?
A. Yes.
Q. Okay. So that is not an issue for debate right now, correct?
A. No. In fact, I am referring to basically the pleural asbestosis. Maybe I should have been more clear about the terminology.
Q. Does that concern you, whether you may be giving a patient the wrong idea as to what disease he or she has, if you were to call it asbestosis, when they only have pleural abnormalities?
A. No, not really. And, in fact, the people in Libby have generally called it that themselves. It's the general overall blanket for anything that they've got that's asbestos-related.
But, you know, most of the time I talk to them about asbestos-related pleural disease and don't use the term "asbestosis." And sometimes I do.
Q. Let's talk about an example. Someone like Cameron Foote.
A. Uh-huh.
Q. Believed that at the age of 41 -- Cameron

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Foote, for example, believes that he has asbestosis. He has testified to that effect.
A. Hmm.
Q. I've looked through your records on him. He has pleural plaques. Is that correct?
A. Yeah.
Q. Okay. So, he has pleural changes only, but he believes that he has asbestosis.
Correct?
A. Yeah. And I think that comes about just because of the way people in Libby view all of this, a lot of it.
Q. How important is the precision of diagnostic labeling in the medical profession?
A. Well, generally, it is. But in this particular situation it probably doesn't make a whole lot of difference, because of the fact that this is a very large community, many of whom have maybe, at least a third of whom have asbestos-related changes on their x-rays.
And, so, whatever they want to call it, it is probably easier for them to relate that they have asbestosis to each other, than to say that they've got a pleural plaque or something like that.
And the ones that are more knowledgeable will

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discuss it in terms of pleural plaque.
Q. But according to the 2004 statement, the '86 statement, and the Helsinki criteria, it would not be correct to tell somebody like Cameron Foote that he has asbestosis, correct?
A. I don't know that I told him that.
Q. Okay. But he has testified to that. But you are not sure if you told him that?
A. No. I'm not sure that I have told him that.
Most of the people that I have talked to, I've told them that they have -- Well, I will tell them that they have asbestosis, if they have fibrotic changes on their chest x-ray, or subpleural fibrosis. But I will generally tell them that they have asbestos pleural thickening.
Q. But it does not surprise you that he claims that he has asbestosis, does it?
A. No, it does not surprise me at all, because of the climate in Libby.
Q. Aren't you concerned that this is creating a climate where people believe that they have diseases that they do not?
A. I think they have it all in perspective, frankly, in general. I don't think it's creating any significant confusion or anything else, no matter what

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they call it.
Q. Well, asbestosis is a very serious disease, correct?
A. So is pleural thickening.
Q. Well, let's talk about asbestosis. Interstitial fibrosis can cause loss of long function, correct?
A. Yes.
Q. It can lead to death, correct?
A. Yes.
Q. According to the Helsinki criteria, pleural plaques alone are markers of exposure, correct?
A. Well, according to the -- That's true. They are markers of exposure. But they also, after you get experience with looking at CT-scans and things like that, they are the harbinger of more disease, and they are also the harbinger of the progression of that over a period of time.
Q. The harbinger, meaning that when you see a pleural plaque, you will see interstitial fibrosis down the road?
A. You may. Or you may see diffuse pleural thickening, or subpleural fibrosis. You may see more on CT. It's not --
And they recognize that in the ATS thing,

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that a pleural plaque is a disease, for the first time, something that everybody that deals with this realized for a long while.
Q. Well, hold on. I thought you said there was no pleural asbestosis. Have they used the term --
A. No. They do recognize that pleural plaque is a disease.
Q. Do they use the term "disease" anywhere in this statement?
A. I will have to take a look at it. But I think they do.
Q. Why don't we look at that at lunch, in the interest of time. I do not believe they refer to that as a disease. And it's hard to prove a negative.
However, in the interest of time, I'd like to move on at this point, away from that particular issue. We can revisit that if you like.
A. Yeah. We will revisit it.
Q. You recognize that the interstitial fibrosis is distinct from a parietal pleural fibrotic process, correct?
A. It's all part of the same spectrum. That's the point that I make. And mainly because of the fact that we have watched so many people with pleural thickening develop subpleural fibrosis, and it becomes

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evident throughout their whole lungs.
Q. But this is what I want to make clear. When you talk about this continuum, fibrotic process, that's what's occurring with asbestosis, correct?
A. Uh-huh.
Q. Fibrosis, correct?
A. Right.
Q. And it's caused by asbestos bodies within the air sacs, correct?
A. Or against the pleural. It's the same cause for both of them.
Q. Well, what term do you use for the air sacs?
A. Alveoli.
Q. So, you have asbestos bodies lodged in the alveoli, correct?
A. Uh-huh.
Q. You have to say --
A. Yes.
Q. And that leads to an inflammatory process, correct?
A. Yes.
Q. And that leads to fibrotic changes within the lungs, correct?
A. Yes.
Q. And when you have diffuse fibrotic changes

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throughout the lungs from this fibrotic reaction to asbestos bodies, that is asbestosis, correct?
A. Yes.
Q. Okay. Fibrotic changes on the outside of the pleura, the parietal pleural, what are those called?
A. They are called either clots or diffuse pleural thickening.
Q. Would you say that diffuse pleural thickening refers more to the fibrotic changes of the visceral pleura?
A. They may refer to both.
Q. But are pleural plaques more often involving the parietal pleura?
A. No. More often -- Most of the changes that you wind up seeing are on the visceral pleura, and you see pleural plaques on the parietal pleura very frequently.
Q. So, pleural plaque on the parietal pleura, that's the area, that's the outer area of the pleura, right?
A. Right.
Q. And, so, is it your view that the fibrosis just migrates from the parietal pleura to the visceral pleura to the outer regions of the lungs and then to the base of the lungs?

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A. Well, think about it for a little bit. How do you get a plaque on the parietal pleura if you don't have it in the lung adjacent to it to get it there in the first place? That's how the fibers got there. I mean, they didn't come through the chest wall.
Q. I understand. But the fibrotic changes that cause asbestosis are independent of the existence of the plaque. They are caused by the fibrotic changes of the asbestos bodies within the air sacs, correct?
A. Yeah. You can say that if you want to. But that's like saying that, maybe a good example, I'll try to come up with a decent example with pneumonia or something, if I can come up with something quickly.
You know, when you've got a pleural plaque, or you've got a pleural thickening, or asbestosis, you've got asbestos fibers throughout all those areas. Okay?
And we have seen so many people with a pleural plaque, Grace's own x-rays have shown this, develop diffuse pleural thickening, develop pulmonary fibrosis, or asbestosis, over a period of 20 years.
And it's obvious that there's a sequence of events, and the pleural plaque doesn't exist as just a beauty mark or a marker there that they had exposure. It's part of the whole process. It's just that it's early in the process.

So, it's like saying that you don't have pneumonia until the whole lobe is involved, it's just a little infection over here that doesn't account for anything.

Q. Something like gangrene.

A. Uh-huh.

Q. That literally spreads, correct, throughout the body?

A. That's a bad example.

Q. Okay. I'm talking about some type of process where the inflammation is actually just spreading.

That is not what you're describing with the pleural plaque asbestosis. You are talking about fibrotic changes on the outside of the pleura and then independent fibrotic changes that are occurring inside the interstitium for those to develop asbestosis, correct?

A. I don't think it's independent. Because if you have seen on those x-rays, that there is a pleural plaque, and it gets larger, and the plaque gets larger, and the next thing you're seeing is extensive pleural thickening. And the pleura becomes fused, both of the pleural surfaces, the visceral and the parietal pleura become fused at that point in many of the people that have diffuse pleural thickening.

And how do you know? You really can't say that that plaque doesn't have anything to do with it. It's all part of a continuum that if you've got the plaque, it may develop into diffuse pleural thickening in that locale. Whether it's parietal or visceral pleura, it's all part of the same sequence of events.

Q. I understand that.

A. So, just because you say there's interstitial asbestos fibers present over here, that there's not the same situation through the whole thing, does not make any sense. It doesn't make sense from a medical standpoint, a clinical sense, or even just a logic standpoint, that they would be all -- they'd be independent of each other. They aren't. There is no way they can be.

Q. Why not?

A. Why not?

Q. Right.

A. Because there are some that have gone on and progressed.

Q. I recognize that these two independent disease processes can develop. However, to suggest that, you know --

I hear what you are saying on the fusing of the parietal and visceral pleura.

A. Okay.

Q. But this image that you're creating with this language of continuum is one of just this migration of fibrosis across to this subpleural region of the interstitium, and then into the lower levels of the lungs. That is the image that your language is invoking, at least in me.

A. You know, you're getting --

MR. HEBERLING: Objection. Misstatement of the testimony.

THE WITNESS: You get plaques also on the visceral pleura. Okay? And most of the time on x-ray you can't tell where they are, whether they are on one or the other. They may be on both, they may be only on one.

You know, you're basically saying that somebody can, like somebody that has an infectious disease, that they can have a little bit of an infectious disease here, and the pneumonia develops out here, and this has nothing to do with it (indicating). That's nonsense.

This is all part of the asbestos disease. It's a continuum. It's a spectrum.

Q. Is there a causal continuum?

A. Yes, there is. It is called the asbestos finer.

Q. No, no, no, no. I mean from between the

pleural plaque to the asbestosis.

A. It meets Koch's postulates. It's the same thing that you use for bacteriology. You have the organism, it causes the infection, you give them back the organism, it causes another infection, and then prove that they are related.

The same thing with asbestos fibers.

Q. Let me make sure I understand this, and I will restate this, I want to make sure I'm clear.

So, your contention is that if there is a fibrotic process of the parietal pleura, this may cause interstitial fibrosis?

A. It may not. It may not directly. But it's all part of the continuum of the disease.

And you say it's a marker of exposure. I say it's a marker of disease.

Q. But my question, though, is whether it is causal. You said earlier that it was causal. That a plaque could cause asbestosis.

A. How do you --

MR. HEBERLING: Objection. Misstatement of the testimony.

THE WITNESS: How do you know? You've got fibers everywhere in here in large numbers.

Q. (BY MR. STANSBURY:) Okay.

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A. You're trying to say that asbestosis is a different disease than a pleural plaque.
That's nonsense. The radiography, pathology, fiber counts, everything, tells you, no, that isn't the case. That's nonsense.
It's all part of a continuum.
Q. I think to call it nonsense would be to fly in the face of the statements of the ATS guidelines in the Helsinki criteria. I don't consider what they say nonsense.
And they do call them distinct disease processes.
MR. HEBERLING: Objection, argumentative.
Q. (BY MR. STANSBURY:) You are using the term nonsense, Dr. Whitehouse. That's a strong term of art. To say something is nonsense when the ATS criteria recognized the distinct aspect of these disease processes, that's a strong statement.
A. Yeah. And you know what, they are ultimately probably going to eat their words, because there will be a paper coming out that shows the continuum between plaques, interstitial disease and a large number of people.
Q. And that's the paper that we talked about at the very beginning of this deposition, correct?

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A. I don't think we've talked about that one particularly very much.
Q. There is another one?
A. You don't know about that one. It is not in publication yet.
Q. Are you involved in this paper?
A. No.
Q. Okay. Who is involved?
A. Some radiologists, and I don't even remember their names.
Q. And does it involve Libby?
A. Uh-huh.
Q. Yes?
A. Oh, yes.
Q. Do they work with you on this?
A. No.
Q. Do they work with Dr. Black?
A. To some degree, yes.
Q. Okay. And did Mr. Black facilitate the transfer of the radiographs to these individuals?
A. I don't know whether he did or not. But the CARD Clinic cooperated.
Q. This is very important. Because you are talking about this continuum. And to the extent that this continuum exists, I do not think it's consistent

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with some of the other literature. But to the extent it exists, I would really like to know more about a study coming out that would support it, because I would think that would be highly relevant to this opinion, don't you?
A. I don't know whether it will be out this summer or not. It is still being reviewed by the authors. It will be eventually. But when it is, I know it is about ready for publication.
Q. Do you know which journal, by any chance?
A. Chest.
Q. Chest. So it is an article in Chest that is going to demonstrate this continuum of disease from pleural plaque --
A. Uh-huh.
Q. -- to --
A. To interstitial disease.
Q. -- to interstitial disease.
A. And I've got two x-rays of patients of mine, and I assume they are probably in this study, I would guess.
Q. I am handing you what's been marked as Exhibit 44. Do you recognize this document, sir?
A. It's a paper that I wrote.
Q. Okay. And this is the 2004 paper we discussed earlier, correct?

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A. Uh-huh.
Q. Yes, sir?
A. Yes.
Q. And this is one of the papers that is relevant, as you have said, to your opinions in this case, correct?
A. Correct.
Q. Okay. Can you look on page 221, upper right corner, of this document.
A. 221?
Q. Yes. The upper right corner.
A. I don't have any page numbers up there.
Q. You don't have page numbers? We can go off the Bates numbers. That's fine. But it's your paper. I thought you might be more familiar with the page numbers.
A. The page numbers didn't come through on this.
Q. Oh, how unfortunate. 2009_01098.
A. 09 what?
Q. 8?
A. 8. Okay.
Q. It's the third page of the document. That may have been the easiest way to do that.
A. Oh. This one does have a number on it. Some of the others don't.
Q. Good. So, we are looking at the left column.

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It begins with "Two or more."
A. Uh-huh.
Q. I'm going to read, and tell me if I read this correctly. "Two or more sets of pulmonary functions were available on 153 patients. These subjects are representative of the Libby area population and the practice group of 491 patients. All had lived in Libby the majority of their life prior to 1990."
A. Yes.
Q. "The majority of the 123 patients were ex-smokers with eight of 123 (7 percent) being current smokers."
Do I have that correct?
A. Yes.
Q. I want to go back up to that first statement. Second sentence I read. "These subjects are representative of the Libby area population and the practice group of 491 patients."
Is that correct?
A. Yes.
Q. Okay. Now, this is published in the American Journal of Industrial Medicine, correct?
A. Correct.
Q. And if I go online and find this article in that journal, I'm going to read this and it's going to

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say, these subjects are representative of the Libby area population, correct?
A. Correct.
Q. Okay. I'm handing you what's marked as Exhibit 46. This is the Libby expert response to the Dr. Weill report by Dr. Alan C. Whitehouse, Dr. Arthur L. Frank, May 8, 2007.
A. Okay.
Q. Do you recognize this report, sir?
(Pause in the proceedings).
Q. And specifically I wanted to direct you --
A. Where's the signature page?
Q. You know, I don't see the signature page on this copy.
A. I don't either.
Q. Well, I'll ask you a question about it. If you don't agree with what I say here, and you question the validity of the document, we can address that. But if you look on 2009_01115, which is page 12 of the document.
(Pause in the proceedings).
A. Okay.
Q. Halfway down the page, 10.4.
A. Uh-huh.
Q. I'm going to read from this. Tell me if I

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read this correctly. "The statement at Whitehouse (2004), page 221, is clarified to read as follows. 'These subjects are representative of the Libby area (asbestos disease) population and the practice group of 491 patients.'"
Did I read that correctly?
A. Yes.
Q. Do you agree with that statement?
A. Actually, I do. He put in here, I did, or Arthur did, the disease population in parentheses, and that's for asbestos disease. And that's reasonable.
Q. Okay. So, is it fair to say that what is in your paper where it says that these people are representative of the Libby area population, is not true? In fact, these people are representative of the people in Libby who have disease, is that correct?
A. Well, that's a matter of splitting hairs. But, yeah, it's probably true.
Q. Well, I think it's important. I think the idea of something being representative is certainly an important concept, correct, sir?
A. Well, except that everything deals with the 491 patients in the practice who had changes. So, you can do it any way you want to.
Q. Well --

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A. It is representative of it. I think, you know, I think his criticism is wrong. I think it's overkill.
Q. Well, let's back up. Putting aside the issue of whether it's representative of the 491 people, you say in your paper, "These people are representative of the Libby area population," meaning that what occurred in this cohort represents what's happening in the Libby area population.
Correct?
A. Well, in a sense, it is certainly related to the asbestos disease population, which includes about now a third of the population. So, maybe I am splitting hairs a little bit.
But I don't think that's a big fault that's in there. It may have been better written, but it's not worth arguing over.
Q. But you are now recognizing it should have read "asbestos disease population"?
A. Yes. It might have been better to read it that way.
Q. Did you alert the Journal of this change?
A. No, I didn't alert the Journal of the change. Why would I? You've come up with this long after this thing was written, you know. People understand things

like that. There's minor errors a lot in papers like that.
Q. This paper identifies rapid progressive loss of lung function --
A. Right.
Q. -- in a patient population.
A. That's right. It does.
Q. And you say that is representative of the Libby area population.
A. You know, you're splitting hairs, again. It is generally representative of it.
But it's the asbestos, it is very clear from the rest of the paper, that that is what I was talking about. Okay? So, what you're doing, you're making an issue out of something which is really probably not much of an issue.
Q. It is not an issue as to whether it is representative or not?
A. No. It's that the paper defines it much better as it goes through the whole thing. Okay?
Q. Defines what?
A. What I just said. That it is representative of the asbestos group, of people that have asbestos disease. Particularly the practice group, of all the patients that I had in the database at that time.

Q. Now, in this study you had the x-rays of individuals and in some cases the HRCT's classified --
A. Yes.
Q. -- by a radiologist, correct?
A. Yes.
Q. And that was Dr. Gordon Teel?
A. Yes. Now, he looked at the first film, okay? That was deliberate, to have him look at the first film. And then he had CT's to look at also to verify the first film. Because there were some of them that were truly negative or very critical --
Q. Okay.
A. -- which were confirmed by CT.
Q. But you didn't publish the individual findings and corollate the individuals who had pleural abnormalities with lung function loss, did you?
A. The degree, no. But that was done. Because he and I looked at the extent of the pleural thickening, and then I did the correlations statistically, and there wasn't any. And I think that may be in here. I'm not sure.
Q. This is a different question.
A. That is in there.
Q. And we can address that in a moment. The question, I'm reading from the same page, "A total of 67 of 123 --

(Cell phone ringing).
A. Is that mine?
Q. I think that's the cell phone.
MR. HEBERLING: I think you need to clarify what you are reading from.
Q. (BY MR. STANSBURY:) The same page, bottom of the page, right above the chart.
A. Yeah.
Q. "A total of 67 of 123 (55 percent) had no evidence on chest x-ray or HRCT of interstitial changes."
A. Right.
Q. "The remaining patients (56) had minimal radiographic evidence of irregular interstitial changes involving the bases at profusion category of 0/1 or 1/0."
Did I read that correctly, sir?
A. Yes.
Q. So, if I understand this, some of these people had interstitial changes, and some of these people did not.
Is that a correct characterization?
A. No, no. They all had pleural changes.
Q. No. I said interstitial.
A. Yeah. But a certain percentage of them did have interstitial -- minimal interstitial changes, as well.

UNIDENTIFIED SPEAKER: Excuse me. There is a lot of beeping coming through.
MR. SCHIAVONI: Is the battery dead?
MS. LEE: No. I think somebody might have put it on hold. I can turn the volume down.
MR. STANSBURY: Yeah. Turn the volume down.
Q. This paper, taking a step back, identifies a rapid decline in DLCO amongst individuals with pleural abnormalities, is that correct, sir?
A. That's correct.
Q. And I think it was above 3 percent, is that correct?
A. Yeah, something like that, 3.0 or 3.2.
Q. Okay. However --
A. 3.0.
Q. -- some of the people had interstitial changes as well, correct?
A. Yeah. Very minimal. A lot of them were 0.1's, and a lot of them, Gordon didn't read those.
Q. He didn't read them?
A. He didn't -- the 0.1's, he didn't think they were significant.
Q. Okay. We discussed earlier, however, that

interstitial changes can cause decrements in DLCO's, correct?
A. Yes.
Q. So, individuals who have interstitial changes and pleural abnormalities, you can't tell whether it's the pleural change or the interstitial changes that's causing the decline, correct?
A. Well, yes, you can, from a standpoint of the fact that ILO nomenclature is 0/1 or a 1/0 doesn't necessarily represent disease. And there's no certainty of disease based on those two categories.
Q. So, you're saying a 1/0 does not represent disease?
A. Doesn't necessarily. It may very well. But you yourself, or the compensation committee or whatever they are called, has excluded anything other than 2/1. And, so, there's always that equivocal nature of a 1/0 or a 0/1.
Q. But you didn't publish in this paper the number of people who have a greater 1/0, did you?
A. No.
Q. And you only had one B-reader, correct?
A. I didn't have any B-reader.
Q. No B-readers.
A. Gordon Teel, although, is a pulmonary board

of radiologist.
(Beeping on phone is continuing).
MR. GUY: This is Jonathan. I don't want to interrupt, but is there any way --
MR. STANSBURY: Let's hang up and call back again. I am going to terminate the line, and call back in.
Let's go off the record momentarily.
THE VIDEOGRAPHER: Yes. We are going to go off the record. The time is approximately 12:07.
(Noon recess).
THE VIDEOGRAPHER: This is the beginning of tape number 3 of the deposition of Dr. Alan C. Whitehouse. The date is March 19, 2009. The time is approximately 12:41. We are back on the record.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, going back to your study, if we could turn to page 2009_01097.
(Pause in the proceedings).
Q. And looking in the left column, the paragraph before Materials and Methods, halfway down there is a sentence that begins "They were examined." After that it begins, "The patients were either referred by internists and family practitioners or were self-referred."
Do you see that sentence, sir?
A. Uh-huh.

Q. Yes, sir?
A. Yes.
Q. Did I read that correctly?
A. You did.
Q. And I believe you were questioned about this in a previous deposition, about the issue of referral, and I believe you testified as follows. I am happy to provide this testimony if you want it.
"If there were people that the lawyers had told us to see, they still came on their own volition, so I still consider that a self-referral. I didn't get referral letters from lawyers sending patients to me at all."
Could I have the deposition transcript, please? Let's look at this. Exhibit 56, which is the October 18, 2007 deposition in this proceeding.
Do you remember this deposition, sir?
A. Yes.
Q. And you were under oath, correct?
A. Yes.
Q. Okay. On page 204 of this transcript, which is towards the back.
(Pause in the proceedings).
A. Okay.
Q. If you would look at line 10, and read from

there to, say, line 18.
(Pause in the proceedings).
A. Yep.
Q. Out loud, please.
A. Which one is that?
Q. Line 10 to line 18, out loud, please.
A. Question. Okay.
Q. Could you read that out loud?
A. Okay.
"QUESTION: The patients were either referred by internists and family practitioners or were self-referred. Correct?
"ANSWER: That's true. And if there were people that the lawyers had told us to see, they still came on their volition. So I still consider that a self-referral. I didn't get referral letters from lawyers sending patients to me at all.
"QUESTION: This is a document that he originally received from the CARD Clinic in connection with one of the first productions. We can mark that as Exhibit -- wherever we are."
Q. So, it is fair to say that you said, with respect to your study, "if there were people that the lawyers had told us to see, they still came on their own volition. So I still consider that a self-referral. I

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didn't get referral letters from lawyers sending me patients at all." That is your testimony?
A. I believe so. I don't recall getting any.
Q. I'm handing you what has been marked as Exhibit 57. Actually, let me see that for one second, please, if I could have that back. Sorry about that.
I'm handing you what has been marked as Exhibit 57. This was a record produced to W.R. Grace in March of 2006 by the CARD Clinic under the direction of the U.S. Government in connection with the criminal case, and these were the records for the individuals whose records were the basis of your published study.
And here we see a letter dated December 14th, 1995, and it begins, "Thank you for referring" blank, and the person's name is redacted, "for evaluation of asbestosis."
Did I read that correctly?
A. Yes.
Q. And the recipient of this will is redacted, correct?
A. Yes.
Q. If you will turn to the next page, please.
A. All right.
Q. Last line before "Sincerely yours."
A. Okay.

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Q. "Thank you for referring him for an evaluation."
Did I read that correctly?
A. Yes.
Q. All right. Now I am going to hand you what has been marked as Exhibit 58. Keep this letter here, please. This letter was produced to us a month later, redacted, by the U.S. Government, and I believe that you will see that Exhibits 57 and 58 are identical.
Do you see that?
A. Obviously I wrote a letter.
Q. Now, who was the recipient of the letter on the December 14th, 1995 letter?
A. Mr. Heberling.
Q. Jon Heberling. So, this is an example of a referral from an attorney, correct?
A. I guess you would have to consider that, yes. I made an error.
Q. You said "Thank you for referring," correct?
A. Yes.
Q. But you had also said that there were no letters, correct?
A. I didn't recall any at the time that I was deposed.
Q. Okay. I'm handing you what has been marked

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as Exhibit 59. And if you will compare this document to Exhibit 58, the patient identifier, 550-493.
(Pause in the proceedings).
Q. And this is indeed, if I am not mistaken, a letter from Mr. Heberling, referring this individual to you, correct?
A. And then on the bottom it says DNKA, did not keep his appointment.
Q. Did not keep his appointment. But judging by your letter here --
A. He must have later, yeah.
Q. All right.
A. He had an appointment in October, and he didn't show.
Q. Okay. This was a person referred by Mr. Heberling, then, correct?
A. I assume it, yeah.
Q. Which would be inconsistent with your earlier testimony, correct?
A. Which would be what?
Q. Inconsistent in your testimony in the previous deposition, in which you said there were no referrals and no letters.
A. I guess you are right. Unfortunately, the reason it got dropped is because the guy didn't show up

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the first time.
Q. Okay.
A. And then did on his own.
Q. I'm handing you what has been marked as Exhibit 60. Do you recognize the handwriting on this piece of paper?
A. No.
Q. This was a note given to me by Nurse Kimberly Rowse at the CARD Clinic. Is that Nurse Rowse's handwriting?
A. It probably is, yes.
Q. She's the head nurse at the CARD Clinic?
A. Yes, she is. Yeah. Well, she's sort of the manager there, yeah. I guess that is her handwriting. It is in pencil, isn't it.
Q. I am handing you what has been marked as Exhibit 61, and this is a letter dated October 13 -- August 13, 1997. Once again, for LP055. Another individual from your study. This is produced in March of 2006 where the redactions were handled through the CARD Clinic.
What does it say above the addressee of this letter, which has been redacted?
MR. HEBERLING: Objection. We don't know that this person is from the study. I mean, you're

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representing that. But the record does not so reflect as of yet.
THE WITNESS: I can't read it.
Q. (BY MR. STANSBURY:) What about before "Thank you"? What does that say?
A. "Referring M.D."
Q. What does that mean?
A. I don't know.
Q. What does "referring M.D." mean?
A. It means that there was an M.D. that may have referred the patient. But it says, "Thank you for referring him," and there is something crossed out. It is very short. So, I don't know what it is.
Q. Okay.
A. I have no idea whether it was anybody even in this study.
Q. But the doctor who referred this has been redacted, correct?
A. I guess. I'm sure it is, yeah.
Q. Okay. I'm handing you what's been marked as Exhibit 62. If you will look, this is also a letter from August 13th, 1997. This was produced in April of 2006. The redactions were handled by the U.S. Government at this time.
Now we see under what was "referring M.D." on

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the previous exhibit, the recipient of this letter was Jon Heberling, attorney.
A. I see that. And again, who's the patient?
Q. The patient, the information has been redacted from us, is LP, if you look at the document. He was LP055, was how it was produced to us in March of 2006. We were not permitted to know the names, and personal identifiable information was redacted.
The broader patient records were produced to us in April of 2006, and we received this record, and this 550 was from the 550 database that you referenced in your report.
A. Yeah. But that wasn't necessarily the ones that were in here either.
Q. But that's the same person, isn't it? Look at those letters.
A. Oh, yeah. It's the same person, yeah.
Q. So, the first letter, the LP055.
A. Yeah.
Q. Okay. This is clearly a referral from Jon Heberling, is it not?
A. Well, it is or it is not. It says "Enclosed is a copy of the workup I did." I write sometimes -- what happens is I ask the patient about referring physicians or anybody that they want me to send the

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workup to, and then I will send it with a cover letter. And this is a typical cover letter.
When somebody refers it, I usually say, thank you for referring somebody. This one says, "Enclosed is a copy of the workup."
I don't know that he referred the patient at all. I have no idea.
Q. If you will look at the bottom of Exhibit -- I'm sorry. Which Exhibit Number is unredacted?
A. This one?
Q. Yeah. What Exhibit Number is that?
A. What is the number?
Q. Yes. Exhibit Number.
A. Oh. 62.
Q. At the bottom of Exhibit 62 does it not say, "Jon, thank you for referring him." Is that correct?
A. Well, I guess it does, yes.
Q. So, it sounds to me like this is again another referral.
A. It may very well be.
Q. Okay. So, once again, the prior testimony, about there being no referrals in this study, may not be accurate, correct?
A. It may be.

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Q. Okay. I'm handing you what has been marked as Exhibit 63, which is a medical record for LP076 dated September 25th, 1996.
Once again, the recipient of the letter has been redacted in this version produced in March of 2006, but as it says, "Thank you for referring him."
We do not know who the addressee is. Is that correct?
A. It's covered up here.
Q. Right.
A. I assume you have another copy of it.
Q. You assume correctly. I'm handing you what has been marked as Exhibit 64, which is the same letter, also dated September 25th, 1996, for 550-538. Again, this is produced under the direction and redaction of the U.S. government, and once again, the recipient of the letter is Jon Heberling, is it not?
A. How do I know that any of these were in this study?
Q. Well, you produced those records in March of 2006.
A. Yeah. But we produced 500 and some odd records.
Q. In March of 2006 you produced 123.
MR. HEBERLING: Brian, you're going to

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have to establish this in the record in another way. You can't ask him these questions.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, you produced these records through the U.S. government, they were made available for use in the bankruptcy.
MR. HEBERLING: Objection, misstates the record.
THE WITNESS: The government also has the records on the whole database.
Q. (BY MR. STANSBURY:) Which whole database?
A. The 550 that were in my database.
Q. That's exactly what that second record is. It came from --
A. Yeah. But what does it have to do necessarily with this paper?
Q. Because they are the same people.
MR. HEBERLING: Objection, argumentative. Ask him questions.
THE WITNESS: Tell me that it's one of the ones in here, and prove to me that it's one of the ones in here, not just one that's in the 550.
Q. (BY MR. STANSBURY:) Was Jay Swennes in your study?
COURT REPORTER: Say that again?
MR. STANSBURY: Jay Swennes.

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S-W-E-N-N-E-S.
A. I think he was, yes.
Q. All right.
A. Jay Swennes -- There's two Swennes'. There's a Jeff and a Jay.
Q. Excuse me. Jeff. Was Jeff Swennes in your study?
A. I believe he was.
MR. STANSBURY: What Exhibit Number are we on?
THE WITNESS: This was long before that study was even thought about, five years before that.
MR. STANSBURY: What exhibit number are we on?
MS. LEE: 65.
Q. (BY MR. STANSBURY:) I'm handing you Exhibit 65, which is another copy of the December 15th, 1995 letter where you are thanking Jon Heberling for the referral. This letter was produced as part of a PIQ. Again, we see that it is Jeff Swennes --
MR. HEBERLING: Objection. Argumentative and lack of foundation.
Just ask him questions. Don't argue with him.
Q. (BY MR. STANSBURY:) If you want to, you can

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compare that to this letter right here, tell me if they are the same letter, Exhibit 57. They should match.
This confusion over who is who is an issue of CARD's creation, not --
MR. HEBERLING: Objection, argumentative.
Q. (BY MR. STANSBURY:) Is that the same person, Dr. Whitehouse?
MR. HEBERLING: CARD --
THE WITNESS: It looks like it was. But, you know, I didn't create any -- If you have problems with CARD, it's nothing that I had anything to do with. Your people came in there, made copies of charts. The feds made copies of charts. I had nothing to do with any of that.
Q. (BY MR. STANSBURY:) Well, clearly --
A. So, don't put it on me.
MR. HEBERLING: In the criminal case, Grace obtained permission to go back to CARD in the two or three weeks before the criminal case started on the representation to the court that they had screwed up all the identifications of the patient numbers, and they didn't know what they had. So, they had to copy it all over again.
Q. (BY MR. STANSBURY:) Is Jeff Swennes in your study, sir?

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MR. HEBERLING: So, if you want to get into an argument on the issues, I think that's a good one.
THE WITNESS: I don't know. Because I don't have my computer here. He may be. He may very well be. I'm very familiar with Jeff.
Q. (BY MR. STANSBURY:) And is that the same letter as Exhibit 57?
MR. HEBERLING: Objection, unclear as to what he is referring to.
Q. (BY MR. STANSBURY:) Which exhibit do you have in your hand?
A. Well, wait a minute. It is not. The typing is different. It's very different. Look at this. This thing is big, broad type. This is little tiny type.
Q. I believe the copies are different. But if you want to look word for word, Dr. Whitehouse, I believe these are the exact same letters. If you can find any words that are different that are unredacted, please do so.
But one looks like it was copied in a much larger font than another. But these are the same letters. Jeff Swennes, as this letter indicates, was referred by Mr. Heberling.
MR. HEBERLING: Objection, argument,

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lack of foundation. None of this is in the record.
(Pause in the proceedings).
THE WITNESS: Whose copy is this (indicating)?
Q. (BY MR. STANSBURY:) That was a copy I pulled out.
A. I see.
MR. SCHIAVONI: I've never in my career seen someone intervene in a bankruptcy and not say who they are as a client. And I have a standing objection to that process taking place here. None of the other -- I don't know what's happened with Grace, but no creditor in this case has consented to people appearing in the bankruptcy secretly.
To the extent we can't cross-examine them because their names are blotted out, I'm being substantially prejudiced.
Q. (BY MR. STANSBURY:) Just so the record is clear, Exhibit 57, a letter that was produced and marked LP072, December 14, 1995, thanking Mr. Heberling for a referral, is the same letter as Exhibit 65, December 14, 1995, in which it's clear that the recipient of this letter was Jon Heberling. It was redacted in Exhibit 57. It isn't here.
Do you still stand by your statement --

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MR. HEBERLING: Objection.
MR. STANSBURY: Allow me to finish my yes.
Q. Do you still stand by your previous statement that none of the individuals in your study were referred to you by Mr. Heberling?
MR. HEBERLING: Objection, compound. There are three or four issues there. Misstates the record.
THE WITNESS: There may have been a couple in there.
Q. (BY MR. STANSBURY:) Okay.
A. And I may have made a mistake on that. So, what?
Q. Well, you make a statement in your paper which is consistent.
A. Okay. But, you know, how many years is that before I even started to work on that paper? That's six years before that.
Q. So, six years before Mr. Heberling is already bringing you the people who are going to be in this study?
A. He is not bringing me people because they are going to be in the study.
Q. He is bringing you people because he wants

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clients, is he not?
A. No, he is not, particularly. He is bringing them because he -- I think if he sent people to me, it is because they trust me to make, you know, honest representations of what's wrong with them, make diagnoses appropriately. It had nothing to do with the study.
Q. Is Jeff Swennes somebody who is a Libby claimant?
A. Yeah. I don't know that I knew that at the time. How did I know that? I see all kinds of people that I don't know whether they are claimants or what they are.
Q. But this individual who you believe is in your study --
A. Yes.
Q. -- was referred by Mr. Heberling six years before you wrote the study?
A. You know, what may have happened in some of these things also is that the patient comes in and they tell me that Mr. Heberling thought that he could come in, or there's a guy in Great Falls that occasionally sends stuff over, too.
And, so, I ask him, "Do you want me to send a letter to your attorney about that?"
And they say, "Yes."

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So, I send them a letter. So, some of them may have been referred. Some of them may have just told me that that was their attorney and they wanted me to send a letter. And I'll send a letter, like it is a referral letter. It's just common decency in the medical practice, you know. So, there may be a couple. So what?
Q. Is Mr. Heberling in the medical practice?
A. No. He's not in the medical practice. You've missed the point. Okay? The point was, that I do send referral letters to people, sometimes even if they are not referred, as a common courtesy, if the patient wants me to do it. Okay?
Q. But you specifically say, thank you for referring him for an evaluation, correct?
A. I just answered that. Okay? I said, sometimes I send referral letters to the doc's that didn't refer it, as a common courtesy because the patient wants me to do it.
Q. But that's not Mr. Heberling, is it?
A. Well, but it doesn't matter whether it's doc's, lawyers, insurance companies, whatever. I mean, that's just the way I dictate sometimes.
I don't know for sure that he had actually said -- Maybe he did. He might very well have sent him.
But, you know, you're making an issue out of

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something that occurred probably, I would guess, six years before I even thought about doing this study, after I had enough data that all of a sudden it hit me that these people were getting a whole lot worse.
Q. But is it fair to say that one of the people who may have assisted you in the introduction of the patients who became the subject of this study was Mr. Heberling?
A. Oh, he might have, he might not have. I mean, I've been seeing patients in Libby since 1970. I've seen a huge number of people with asbestos disease. The word is out. If you want to see somebody to make a diagnosis, look at things critically, go see me. I mean, that word has been out in Libby for the last 15 or 20 years.
Q. So, you're the person they would come to anyways?
A. They would come to me anyway.
Q. Because you're the person that will give them, as you put it, the critical look?
A. Yes, that's right. And, you know, for all the ones that you see here that have disease, there's probably an equal number that I didn't find anything on, and told them so.
Q. Do you have a list of people that you told --

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A. No, I don't have a list of that. I don't keep a list like that.
Q. Why is that?
A. Because I'm a practicing physician. You know, I don't do all this work that I do with this, just because of lawyers, or keeping lists because I think that some day somebody like yourself is going to be questioning me.
I don't do that. I practice because I take care of people. That's my primary job. And to advise them and give them advice concerning what they have and what they might expect. And then to follow them up over the years and tell them what's going on. That's my job.
Q. But it might not necessarily entail advice as to what people like Dr. Becker may say who disagrees with you?
A. I already answered that.
MR. HEBERLING: Objection. Asked and answered.
THE WITNESS: I already answered that. I'm not even going to answer it again. Okay?
Q. (BY MR. STANSBURY:) Okay. Could we look at your report for one moment, please?
A. Which one?
Q. Your expert report.

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A. Sure.
Q. I'm reading from the report, if you want to follow along, just to make sure I'm clear.
(Pause in the proceedings).
Q. Actually, can I see it for a moment again, please? I apologize, sir. I'm handing you -- This is an older one.
(Pause in the proceedings).
Q. Do you have this? I am reading a statement from your 2006 expert report in the bankruptcy case. "Since 1980 I have evaluated or treated over 700 patients for asbestos disease from Libby asbestos. Since about 2000 patient data has been tracked on a database."
Is that an accurate statement?
A. Where is this?
Q. This is in your previous record. I will show you the page.
A. Yes. You need to.
Q. It is more as to whether that statement is correct.
A. Yeah. That's correct.
Q. Okay. So, you are keeping this information on these people, then?
A. You know I am. I don't do it anymore.
Q. Okay.

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A. There was 550, and you knew it, you made copies of everything, you made a big deal out of the whole thing. And it was basically garbage data because I was trying to keep track of patients in my office, when I'd see them in Libby and I would record their pulmonary function studies, so I would have some basis for comparison, so that I knew what I was dealing with with the patient.
That is the reason for the database. It had nothing to do with anything else.
Q. Do you still have it in electronic form?
A. Oh, I probably do. I don't know where it is.
Q. Is it included among the materials that you produced?
A. It was produced to you and the feds. way earlier, I know that.
Q. When?
A. Oh, a long time ago. Whenever you made those copies. You made copies of all the charts.
Q. We copied the charts, yes. But this is talking about a database.
A. Yeah. You have the database. It was made available to you.
Q. When?
A. It wasn't much of -- About the same time, I'm

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sure. I don't know where it is or what you did with it.
Q. But you do remember producing the database?
A. Oh, I know I did.
Q. Okay. All right.
A. If you ask me to produce something, I produce it.
Q. Unless it's a draft paper.
MR. SCHIAVONI: Could we have a copy of it? Does he still have?
THE WITNESS: He's got it. He should have it somewhere.
MR. SCHIAVONI: Well, I don't. I don't. Could I find out, where is it?
MR. STANSBURY: Sure. We'll worry about where --
THE WITNESS: There's a whole lot of problems with it, because there's an awful lot of names in it that are not involved with lawsuits. All kinds of HIPAA issues involved in this. Okay? And somebody went through, I know, and deleted names or crossed them out, ones that were not involved in lawsuits or anything at one time.
But you have it. Okay? And I'm not going to go through and do all the deletions and everything again. I don't have time to do it. And you have it. So, you

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find it. Okay?
Q. (BY MR. STANSBURY:) I want to go back to your study for a moment, please.
A. Okay.
Q. 2009_01097. Bottom right, "Results." It begins, "Of the 491 subjects."
Do you see where I am?
A. Yes.
Q. "Of the 419 subjects, 220 were employees of the vermiculite facilities, 121 were family members, and 150 were environmental exposures."
Did I read that correctly?
A. Yes.
Q. Okay. Now, with respect -- And this is the population that you said the 123 patients was representative of, correct?
A. Yep.
Q. Okay. Let's look at the 123 patients, on the next page, well, you are on that page now, first full paragraph, "The majority of the 123 patients were ex-smokers with eight of 123 (7 percent) being current smokers. Also, 27 (21 percent) never smoked. In total, 86 (70 percent) were former employees of W.R. Grace. 27 (22 percent) were family members of employees, and 10 of 123 (8 percent) were characterized as Libby environmental

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exposures only."
Did I read that correctly, sir?
A. You did.
Q. And that information is accurate, correct?
A. Yes. But these were at the beginning. This 491 --
Q. Right.
A. -- is the number down the line when the thing was finally finished.
Q. Right.
A. And the number of environmental ones had increased, and the number of miners had relatively decreased. Although in relative terms, they are not that different.
Q. Well, based on the -- the 123, it looks to me like 70 percent were former employees. That's correct, right?
A. Yeah. And they were about 50 percent of the overall 291. But there were a lot of other ones that were added to that 429 after I did this study.
Q. Well --
A. Just so we're clear, I believe -- or actually in the interim period of time, but didn't have two pulmonary function studies. Because that was one of the criteria, was two of them.

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Q. It says here, 220 of the 491 were employees, is that right?
A. That's right.
Q. Less than 50 percent, correct?
A. It is less than 50 percent.
Q. So -- and then with respect to environmental cases, 150 were environmental exposures in the 491 population, correct?
A. Where is there? Okay. Yeah. They were. Yeah.
Q. And what percentage is that? Is that about a third?
A. Yeah. Roughly.
Q. Yeah.
A. A little less than that. About 30 percent.
Q. Okay. So, in one study 8 percent are environmental exposures, whereas 31 percent are environmental cases, correct, in the other -- Strike that.
MR. HEBERLING: Objection, unintelligible.
Q. (BY MR. STANSBURY:) In the published study, 8 percent of the 123 individuals are environmental cases, whereas 31 percent of the larger 491 patient population were alleged environmental disease cases, correct?

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A. Yes.
Q. Okay.
A. That's true. Except that there's one thing that you've forgotten about.
Q. What is that?
A. And that is that they had to have two studies.
Q. Oh, I'm not talking about your selection criteria at this point. I'm talking about your statement that they are representative. Okay?
A. Miner difference. Okay?
Q. No. I think it's a significant difference. One deals with who is in the study, the other deals with whether a sub-cohort represents the larger cohort. Correct?
A. Whatever.
Q. No, Dr. Whitehouse, not whatever. Is that correct?
A. Well, you know, you're down to the point where you're really splitting hairs.
Q. Okay.
A. This is not very important.
Q. It's not?
A. It's not very important to the overall text and context of what this study was about. Okay?

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Q. It's not important that --
A. No, it isn't. It really isn't important.
Q. May I finish the question, please.
It's not important that 70 percent of the people were workers, 70 percent with occupational exposures, whereas less than half in the larger cohort do, and that only 8 percent in this cohort have environmental exposures, whereas 31 percent in the large cohort do? Do you not consider that to be significant with respect to whether one is representative of the other?
A. I clearly defined the percentage of people in each group in this paper. I very clearly defined it. 86 in one. 27 of the other. 10 of the other. I don't know how much more clearer I can be.
Q. So, you have --
A. These all came out of a group of people that were seeing me on a regular basis. Now, it turns out there were more.
But on the other hand, there was a lot more miners originally. Now a lot of them have died off, at that time.
Q. I recognize that. I'm not questioning the reason why there was a larger occupational group in the sub-cohort as opposed to the larger cohort.

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I'm asking you whether you believe that it is significant as to whether one is representative of the other.
A. I don't think that that's a significant difference.
Q. So, you don't think that the nature of exposure matters?
A. Let's see what we wrote about this, since I'm sure Weill is the one that --
Q. Page 12.
A. You've got it right on the tip of your tongue, don't you.
(Pause in the proceedings).
A. There's your answer right there, in the last paragraph.
Q. What does it say? Would you hand it to me?
A. It's been so long ago that I wrote this with Arthur, that I can't recall all of the answers to it, unfortunately.
Q. May I see it, please?
A. Yes, you can. Let me clip it back together again. It's page 12, the last paragraph.
Q. Okay.
A. Read it.
Q. Will do. "Weill further criticizes the

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study as not 'representative of the practice group of 491 patients.' Again the criticism is misplaced. It is difficult to say that the 123 patients are not generally representative of the 491 patients, where 123 is 25 percent of the total 491 patients at the time of the study in 2001. 123 patients is a large group. It is fair to say that it is probable that if 123 patients with pleural disease who have two lung function tests are progressing, then the patients with only one lung function test are progressing as well. Scientifically, this is a solid conclusion. Weill does not suppose that it is not. Clinical observation also supports that a majority of patients are progressing. This clinical observation is what prompted the study in the first place."
Did I read that correctly, sir?
A. You did.
Q. Your basic argument is because 123 is about 25 percent 491, that what occurs in that smaller cohort, I will use your exact words, "It is fair to say that it is probable that if 123 patients with pleural disease who have two lung function tests are progressing, then the patients with only one lung function test are progressing as well."
Correct?

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A. Uh-huh.
Q. Yes?
A. And that was not only my opinion. That was also Arthur Frank's, as well.
Q. Arthur Frank's, as well. So, just because it's 25 percent, it doesn't make a difference to you of whether the fundamental exposures of those individuals differ?
A. We don't know that.
Q. Well, you do know that. You know that 70 percent of the 123 were occupational, 22 percent were take home, and 8 percent were environmental, correct?
MR. HEBERLING: Objection. The questions and answers are not matching. Be very clear what your question is so that he can answer it.
THE WITNESS: We have no idea what all exposure levels of all these family and environmental cases are. We have ideas, but we don't know.
And we don't even know whether it makes a difference whether you have 10 percent of that exposure level that the miners had or not. It may be just as bad as having, working in the dry mill. We don't know the answers to that.
Q. (BY MR. STANSBURY:) So, you don't think it matters what the dose of the exposure was?

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A. We don't know what dose it takes to get how much disease. Okay?
Q. Okay.
A. That's the point. I made that point in the criminal trial, too. Okay?
These people have disease. Okay? The family members have disease. We have the environmental cases. And time has borne out, as we've gotten more and more and more environmental cases. It's just the matter of at what time frame they were exposed.
Q. Do you believe these 123 individuals are representative of the larger 1800 patient population that you have referenced earlier?
A. There's more miners in there now obviously than there are now. But on the other hand, if you wait 20 years, it may be exactly representative. You don't know. Because you've got different years of exposures in the groups.
Q. What's your criteria for what's representative?
A. I don't have a good criteria. We don't have a good criteria. There's no way to get a good criteria. Because we have people that were exposed in the mine, we have family members, we have people that were exposed in the lumber mill, people that were exposed in the

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community, all at different times.
It would take a large study to categorize exactly when their exposures were and then put them into groups and see what they look like.
They may all look alike. I don't know that. I don't know the answer to that.
Q. So, you do not have a good criteria for determining whether a certain subgroup is representative of the larger group? Is that what you just said?
MR. HEBERLING: Objection, unclear as to the meaning of representative.
THE WITNESS: I don't know what you mean.
Q. (BY MR. STANSBURY:) You used the word representative, Dr. Whitehouse, in your paper. What did you mean?
A. Show me where --
Q. It's on the --
A. Show it to me.
Q. Sure, sure. "These subjects are representative of the Libby area population, although now we know that means Libby area" --
A. Oh. You are talking about that original statement?
Q. Absolutely. You're making representations. You are saying that these are representative. That's a

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significant statement in epidemiology, and you are now testifying that you don't have criteria to do that, and you haven't explained to me how you determined one was representative of the other.
MR. HEBERLING: Objection, argumentative, and misstates the record. He explained it was pleural disease that they have all have.
MR. STANSBURY: Do not guide the witness. I object and move to strike.
MR. HEBERLING: If you're going to be argumentative, I'm just going to have to object over and over again.
MR. STANSBURY: You can state your objection succinctly in compliance with the Federal Rules of Civil Procedure.
THE WITNESS: Repeat the question.
Q. (BY MR. STANSBURY:) Sure. I'm trying to understand what you mean when you say that these 123 individuals are representative of the larger population. I mean, it's a term with meaning. I want to understand what your meaning is.
A. They are representative of Libby area population, and I think it's clarified with the other thing in asbestos disease. And the paper makes it clear that that is what we're dealing with. Okay?

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Q. You did not report the amount of lung function lost based on exposure category, correct?
A. No.
Q. So, we have a cohort of 123 people that are comprised of 86 workers, 70 percent of that population had occupational exposures, correct?
A. That's right.
Q. And you don't report what level of lung function occurred in those individuals compared to the 10 people or 8 percent who only had alleged environmental exposures, correct?
A. Actually all the statistics were done on all of those and there wasn't any difference in them.
And when you are writing a paper like this, and you're writing it for practicing physicians who may read this, as opposed to the academicians, maybe you didn't understand this when you looked at this, I know you didn't, but I used percentage of predicted for pulmonary functions. And that was criticized by the academicians.
But it's not going to be criticized by the practicing physicians, because they want the information in the form in which they use it, which is percentage of predicted.
The same way, practicing physicians, they're

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not interested in all of that garbage, about all the other stuff, the semantics of this. They're interested in what happened to those 23 people and what the numbers were.
And, so, the paper, of necessity, doesn't have every single cottonpickin' detail in it, because it gets to be so full of details that nobody will read it. The practicing doc won't read it, if there's the case. I guarantee you of that.
Q. Do you think this paper is at all relevant to determining whether the people in the Libby community who only have environmental exposures may have disease?
A. No. I didn't say that.
Q. Okay. Making sure we are clear on that.
Moving on, did you report loss of lung function, based on diffuse pleural thickening, as opposed to pleural plaque?
A. No, we did not. They were all grouped together.
Q. Okay. So, you did not differentiate radiographic abnormalities?
A. No, I did not. In that regard. I did relate the matter of interstitial disease.
And in fact, we did go over all of those numbers and determine that there really wasn't any

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significant difference concerning extent, which was just basically, includes the pleural plaques on the one end and the diffuse pleural thickening on the other end of that. And there wasn't a statistical difference between the two.
Q. And your classification of the x-rays was based on Gordon Teel, correct?
A. Yeah.
Q. Okay. He was not a B-reader, correct?
A. He's about 10 steps ahead of any B-reader you've ever seen.
Q. Really? I've seen some pretty good B-readers in my day.
MR. HEBERLING: Objection, argumentative.
THE WITNESS: That is argumentative, and Gordon Teel's an extraordinarily good pulmonary radiologist. And he's pulmonary trained. You don't have to be pulmonary trained to be a B-reader. You can be a general internist and still be a B-reader. Okay?
So, you're making comparisons that are not fair.
Q. (BY MR. STANSBURY:) But he is using B-reading classifications, is he not?
A. No.
Q. 0/1 and 1/0, where do those --

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A. I use those.
Q. Are you a B-reader?
A. I used to be. I'm not now.
Q. Okay.
A. I know what they mean. I know what they look like. And so does he. But he doesn't use them either.
There's only one B-reader in Washington, in Seattle. There's none in Montana. I don't know about Idaho. There's none in Northern Idaho. The reason why, it's not a useful tool.
Q. When the ATSDR came to town to do the mass screening that they did, who read the x-rays?
A. Oh, they had B-readers to read them, yes.
Q. Three B-readers, correct?
A. Yes.
Q. Which is what the Iowa guidelines recommend, correct?
A. Yeah. But that was basically an epidemiologic study. That's not a diagnostic study.
Q. Okay. So, this is --
A. It's not a diagnostic study.
Q. Okay. Well, let me back up, then. Let's get it out --
A. It has epidemiological overtones, and there are epidemiologic fashions of the progression of things

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with this. But it's also a study to document the severity of losses of lung function. It doesn't require a B-reader.
Q. So, this is not an epidemiologic study?
A. Yeah, this is an epidemiologic study.
Q. You just said it wasn't.
MR. HEBERLING: Objection. Misstating the record. Argumentative. That's enough.
THE WITNESS: I did not say that.
MR. STANSBURY: Lower your voice, please.
MR. HEBERLING: That's enough.
MR. STANSBURY: Lower your voice.
MR. HEBERLING: Do you hear me?
MR. STANSBURY: Lower your voice.
MR. HEBERLING: Are you hearing me? Are you hearing me?
MR. STANSBURY: I am hearing you. And I am asking you to lower your voice.
MR. HEBERLING: That is enough. You need to understand that.
MR. STANSBURY: You need to lower your voice.
MR. HEBERLING: You've been misstating the record and arguing with this witness all day long, and that's enough.

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Q. (BY MR. STANSBURY:) Dr. Whitehouse --
MR. HEBERLING: You're telling him he's testified that it was not an epidemiological study. I challenge you to find that anywhere in the record.
MR. STANSBURY: I believe he said it's a diagnostic study with epidemiological overtones.
Q. Did you use that word, Dr. Whitehouse?
A. Yeah, I did.
MR. HEBERLING: That's right. But he didn't say it was not an epidemiological study. Then you asked him the question, and he answered that it is.
MR. STANSBURY: I will ask you to keep your objections within the guidelines of the Federal Rules of Civil Procedure.
MR. HEBERLING: You have abused this proceeding all day long, and this is where we're drawing the line, Brian.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, there seems to be some confusion on the record as to what this study is. Let's clarify that right now.
Okay?
A. The study started out to be a study at looking at what happened to these people diagnostically with their pulmonary function. It is an epidemiologic study in the sense that describes what happened over that

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period of time to these people. Okay?
Q. And this goes back to my previous question. The Iowa guidelines recommend using three independent B-readers for epidemiological studies, correct?
A. Oh, come on. Okay? Where am I going to get in Spokane, Washington, three independent B-readers? Okay? Where do I get three B-readers?
I don't want to deal with B-readers particularly, you know, for epidemiology. This is a study that is a very simple study at heart. Okay? It took a lot of time to do it, but it was very simple in its concept. It doesn't need B-readers to do it.
Q. But it's a study that does not report lung function based on exposure category, correct?
A. It doesn't have to.
Q. But it doesn't?
A. No, it doesn't.
Q. It does not report lung function based upon the appearance of radiographic abnormality, does it?
A. Yeah, actually, it did, because we had done that. We don't report it here, but we had done it.
Q. Well, let's go back to what's in the actual study. Let's focus on that. This is a published study.
This published study does not report radiographic -- Strike that.

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This published study does not report pulmonary impairment based upon specific radiographic abnormality, such as pleural plaque or diffuse pleural thickening, correct?
A. No. Except in the process of doing this thing, Gordon -- and I didn't do this. I just sat there and acted as a scribe. He went through and described the percentage of the chest wall that was involved with this, and then I did the statistics on it to see if it made a difference on the amount that they were losing. And it did not.
And that would have included plaques at one end of it, as I said earlier, versus somebody that had diffuse pleural thickening in the entire thoracic space.
So it was done. It just wasn't worth presenting here.
Q. Dr. Whitehouse, I asked you a yes or no question, okay, and we can talk about your explanation.
But the yes or no question, the answer to that, does this study report pulmonary impairment based on radiographic abnormalities such as diffuse pleural thickening or pleural plaque?
The answer to that question is?
A. No.
Q. Okay. Thank you, sir.

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A. May we have a break for a minute?
Q. Sure.
MR. STANSBURY: We can go off the record.
THE VIDEOGRAPHER: We are going off the record. The time is approximately 1:23.
(Short recess).
THE VIDEOGRAPHER: We are going back on the record. The time is approximately 1:31.
Q. (BY MR. STANSBURY:) Dr. Whitehouse, if we could look at your study on page 220, please, and the tag at the bottom is 2009_01097. The second column. The first full paragraph beginning with "Normal values." About seven or eight lines down, that is discussion about 30 patients who were excluded.
A. Yes.
Q. I am going to read this outloud, and tell me if I get this correct, sir. "In total, 30 patients were removed from the study for the following reasons: Chronic obstructive pulmonary disease with elevated residual volumes (14)," I think that's a comma, "previous thoracic surgery (1), unacceptable pulmonary function tests because of patient unreliability and inability to meet ATS acceptability criteria (9), and/or the presence of a significant non-asbestos related condition such as sarcoidosis or congestive heart failure (9)."

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Dr. Whitehouse, would it be fair to say that this is a portion of your selection criteria for your study?
A. I don't understand what you mean, a portion.
Q. Well, you have criteria for who is and is not in the study, correct?
A. Well, basically, everybody was in the study until I excluded them.
Q. Everybody who had two or more PFT's, correct?
A. And then I excluded the ones which shouldn't be in there.
Q. I am referring to the selection criteria as, you know, the method by which you determined who is and is not in the study.
A. All right.
Q. If I understand that correctly, people with two or more PFT's, and excluding people with other conditions which may affect pulmonary function, is that a fair statement?
A. Yeah. There's one other thing that I probably should have clarified, when I said previous thoracic surgery, because we did not throw out the people with cabbages.
Q. Could you explain what that term means, cabbages?

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A. Bypasses.
Q. Bypasses. So, again, fair to say, then, that people with previous thoracic surgery may have been in the study after all?
A. Well, not people that have resections or anything like that. But people, there could have been somebody that had something miner done in the distant pass, or a bypass. Nothing that would have affected the things in the middle.
And if somebody had any kind of thoracic procedure in the middle of the study, they weren't used.
Q. Okay. So, let me unpack this. That is not obviously what that paragraph reads.
A. It doesn't say that, but that's what was done.
Q. Do you think it is important for the paper to accurately reflect what was done?
A. Not necessarily -- well, I don't know that -- You know, I guess I could have clarified it, but I didn't. So . . .
Q. Is that something you would ever notify the Journal about?
A. No, I'm not going to notify the Journal about it. This thing was published a long time ago, and the data is accurate.

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Q. Okay.
A. I'm not going to notify the Journal about something unless -- The end results of this were very accurate.
Q. But this portion of the selection criteria as stated does not reflect what was done, correct?
A. Well, it does, basically. It probably should have said previous interim thoracic surgery, is what it really should have said.
Q. Okay. I'm handing you Exhibit 66. It is for LP098. It is dated 2-4 -- Excuse me. It is dated February 14th, 2001. This was among the records produced in March of 2006.
Under "Exam," I guess the second paragraph, could you read -- Well, I will read it. "His chest x-ray shows only the changes of a lobectomy and some irregularity of the diaphragm related to some fluid but there is no pneumothorax and the fluid around the apex is also involved."
Did I read that correctly, sir?
A. Yes. I was also referring to the post-operative care, is what I was referring to.
Q. What is a lobectomy?
A. Removal of a lobe.
Q. So this individual had a portion of a lobe of

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his lung removed?
A. Yeah. But this was not in -- this was either after -- this was probably after the second pulmonary function that I use, and before anything was done with the lobe.
Who is this? I don't know who this is.
Q. You tell me, Dr. Whitehouse. It was redacted. It is LP098.
MR. HEBERLING: Objection, argumentative.
Q. (BY MR. STANSBURY:) I don't know who it is. It was redacted.
A. I don't even know whether it was somebody in the study.
Q. Well, the only reason I know is because it was produced by the government from CARD in March of 2006, represented as the patients who underlie your study.
A. You'll have to do something better than that in follow-up, in identification of this, because I have no idea. I know darn well that I didn't have anybody in the interim that had surgery on this study.
Q. Well, Dr. Whitehouse, you may be in a better position than I am to do that follow-up, seeing as how these are your patients.
Would you be willing to do so, so that we can

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come back and discuss this?
A. Well, actually, I am not willing to do it, because I've got a lot of other things to do. You know. I'm getting older. I've got a trial to go through. Another trial with a bankruptcy.
And I don't want to spend time rooting through records, trying to find out who this is.
Q. What is the other trial than the bankruptcy that you are going to go through?
MR. HEBERLING: We delivered to you in December the medical records on the 121 of the 123 patients. You have them.
MR. STANSBURY: They're right here, aren't they (indicating)?
MR. HEBERLING: You don't have to use redacted ones.
MR. STANSBURY: No, no, no. They're in this binder, aren't they?
MR. HEBERLING: I think so. Most of them are in there.
MR. STANSBURY: Let's pop this up and we'll test this out.
MR. HEBERLING: But how do you know who to look for?
MR. STANSBURY: Well, I'm going to see if

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the numbering lines up. This is a CD, 123 patients for Whitehouse 2004.
MR. HEBERLING: We don't use your numbering system. We use names or initials. So, if you've got the name, then we can find the person.
MR. STANSBURY: So, you don't use numbering, do you?
MR. HEBERLING: No. We've seen several numbering systems.
And for the record, also, we don't have everything that was given in the criminal case. We don't even know what discovery was in the criminal case.
So, these numbering systems may or may not relate to anything that we know about.
Q. (BY MR. STANSBURY:) I'm going to call out some names. And if you would, let me know if any of these people have ever had a lobectomy.
A. How am I supposed to know this?
Q. These are your patients.
A. 36 of them are dead. And they are long dead. And this study was done eight years ago.
Q. Miles Rightmire.
A. I don't know.
Q. All right.
A. I don't think so.

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(Pause in the proceedings).
Q. Well, we'll revisit that issue on him. But you don't know whether this person was in your study. But if somebody had had a lobectomy, should they have been removed from your study?
MR. HEBERLING: Objection, unclear as to the meaning of "this person."
Q. (BY MR. STANSBURY:) If a person had a lobectomy, should they have --
A. Not if it was done after the study was concluded, I wouldn't have, no. Why would I have?
Q. All right.
A. It wouldn't have been germane to it.
Q. What about asthma? Did any of these people have a diagnosis of asthma?
A. They don't have clinical asthma. They at one time or another may have had a suspicion of asthma. Some of them had some bronchospasm. But insofar as actually having clinical asthma, no.
Q. All right.
A. Because that's something I did eliminate them from. At the time I did the study, that was either totally controlled, if they had it in the past, or it was bronchospasm that occasionally -- not occasionally -- it is frequently associated with this disease.

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Q. Again, we will have to revisit it to see whether it is the actual person, but LP029, I am reading from a medical record, this is Exhibit Number 69, and it says as follows -- Well, actually why don't you read, where it says, under 4-24-89.
(Pause in the proceedings).
A. Oh. This is the one that had a positive methacholine challenge very distantly in the past.
Q. Uh-huh.
A. And then probably was, by the time it was actually in the study, had it totally controlled.
Q. So, I am going to read this. Let me know if I have read this correctly. "The methacholine results were returned and it is apparent that the patient does indeed have severe asthma, which is manifested as a refractory restrictive defect."
Did I read that correctly?
A. Uh-huh.
Q. Yes, sir?
A. Yeah.
Q. Okay. Was this person in your study?
A. I don't know. I think probably actually it may have been, but I think it was many, many years later, after the asthma was no longer a factor.
Q. Okay. Let's deal with some more unredacted

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records. How's that sound?
A. Whatever you want to do.
Q. Okay. Well, first, ultimately you find a loss of lung function of 3 percent annually in DLCO across the cohort, correct?
A. Uh-huh.
Q. Yes, sir?
A. Yes.
Q. Okay. And what was the measurement for FVC?
A. 2.2.
Q. Okay. And what was the measurement for TLC?
A. 2.3.
Q. Okay. I'm handing you what's been marked as Exhibit 70. Here you go. And it is the "2005 ATS/ERS Task Force: Standardisation of Lung Function Testing. Interpretive Strategies for Lung Function Tests."
Are you familiar with this document, sir?
A. Yes, sir, I am.
Q. And again this is an ATS statement, correct, along with the European Respiratory Society?
A. Yes.
Q. If you would look, and let's look at the 2009 numbers at the bottom right, 2009_08404.
(Pause in the proceedings).
Q. Are you there, sir?

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A. Yep.
Q. Let's look at table 12 on the bottom right. "Reported significant changes in forced vital capacity (FVC), forced expiratory volume in one second (FEV1), mid-expiratory flow (MEF 25 to 75 percent) and carbon monoxide diffusing capacity (DLCO) over time."
Did I read that correctly, sir?
A. Uh-huh.
Q. Yes, sir?
A. Yeah.
Q. And if you look at year-to-year on that table, and, again, this is reporting significant changes, greater than 15 percent for FVC, is that correct?
A. Reported significant changes, year-to-year. Whose numbers are those, under what circumstances?
Q. Well, this would be the ATS and the ERS's numbers.
A. What do they mean?
Q. Well, I believe that would be 15 percent loss of lung function.
A. Not necessarily. You lose 30 cc's a year. Are those absolute numbers or percentage of predicted?
Q. Well, let's see here. Hopefully they have explained that.
A. It doesn't look like.

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(Pause in the proceedings).
Q. Have you reviewed this document before, sir?
A. Oh, I have seen it. I don't know that I have read it very carefully before.
Q. You are not aware of whether that is referring to absolute numbers, 4 percent?
A. I haven't really paid that much attention to it. And it's way out of line with what I know is the case.
Q. You know, you've mentioned earlier that people have had to have two or more PFT's to be in this study, correct?
A. Yes.
Q. And you used the first and last PFT, correct?
A. Randomly used the first and last study that I had available.
Q. So, you used two data points per person, correct?
A. Right.
Q. Okay. Let's look at, right above that table, the text that begins, "It is more." I will read this. "It is more likely that a real change has occurred when more than two measurements are performed over time. As shown in table 12, significant changes, whether statistical or biological, vary by parameter, time period

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and the type of patient. When there are only two tests available to evaluate change, the large variability necessities relatively large changes to be confident that a significant change has occurred over -- has in fact occurred."

Do you see that, sir?

A. Now, you are talking about a single individual patient. When you have 123 patients, you have such a large number of people in there that you've eliminated a great deal of the variability. The statisticians will tell you that.

Q. They recommend using more than two data points, don't they?

A. No. They are talking about for a single person. They are not talking about a group of people. They are talking about a single person.

Q. I don't believe it says that.

A. Well, I know they do, because that is exactly what I do when I am looking at a single person. I see one study, and then I see another one, and if it's changed a lot, I don't really make a big thing out of it until I see it changed a lot the next time.

Q. Let's go down --

A. But on a study like this, some of these people had eight or 10, but it's arbitrarily the first

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one, and the last one, and that's a very highly thought of statistical way to deal with something like that, because it is a random selection in a large number of people.

And that's why I did it that way. And it was checked out with some of the people that were my peer reviewers.

Q. But if you had more data points, clearly that could be better, correct?

A. No.

Q. No?

A. No. Not when you are doing first and last. No. Which one do you take? Do you take the one that shows what you want it to show?

Q. Why not use all the data points?

A. Oh, come on. You are talking about a huge study, if you do all of the data points. Do you know what the statistics are like in that sort of thing?

Q. It's a lot of work.

A. Yeah. You're right. I was trying to practice medicine.

Q. I understand.

A. Okay.

Q. However, you would agree, though, if you have the time, using five, six, all available data points will

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give you a more accurate picture of what this person's lung function is over time, correct?

A. I'm not doing this on an individual. This is group. And you are wrong, flat wrong in your discussion of it. And you don't understand the fact that when you've got a large group, like 123, you eliminate those various errors.

Q. So, you think that it is not the right approach, when you're dealing with a large group, to use as many data points as possible for each person?

A. This is a satisfactory approach to it, and it was checked by -- it was thought to be by the Journal, by the peer reviewers of the Journal, and the peer reviewers that I had peer review it here.

Q. Putting aside the time constraints, recognizing that, would it have produced a more robust data set to use all available data points?

A. No, it probably wouldn't. It probably wouldn't have been any better than to do it this way. I doubt it.

Q. Do you have any literature, are you aware of any study in which they specifically stated it is better to use first and last, rather than all data points?

A. I don't. But I'm sure I'll find one.

Q. Okay. Let's move down on this same document.

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We're on page 2009_08405.

A. Okay.

Q. I guess it's this paragraph that begins with "Test variability." Do you see that, sir?

A. Uh-huh.

Q. Continuing in that paragraph, last sentence, "However, establishing an accelerated rate of loss in an individual is very difficult, and requires many measurements over several years with meticulous quality control of the measurements."

Did I read that correctly?

A. Yes. Except this was not an individual. This was 123 individuals.

Q. I understand. But do you recognize it is better just to have more data points when doing this?

A. No. I already explained that to you, and I already answered that.

Q. Let's move on, in the same document, "DLCO Interpretation." And this speaks to what we were discussing earlier. I want to make sure we are on the same page. Second column. First full paragraph, beginning with "Interpreting."

A. Yes.

Q. "Interpreting the DLCO, in conjunction with spirometry and lung volumes assessment, may assist in

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diagnosing the underlying disease. For instance, normal spirometry and lung volumes associated with decreased DLCO may suggest anaemia, pulmonary vascular disorders, early ILD or early emphysema."

Did I read that correctly, sir?

A. Yes.

Q. So, that would suggest that when somebody has abnormal DLCO but normal lung volumes and spirometry, it would suggest anaemia, pulmonary vascular disease, early ILD, or early emphysema.

Did I read that correctly?

A. You read it correctly. And you know what, it's just off of the wall as far as all the things that can cause abnormal DLCO's I could add 30 things to that.

Q. Oh, I agree with you on that, sir.

A. You know, it's not something that has any bearing on what we're doing here, okay?

Q. I think it does, though.

A. No, it doesn't. Because we have enough documentary evidence over a long period of time of people with isolated DLCO decreases with reasonable spirometry over very, very long periods of time now, for eight years, that we really are very well aware of the fact that a decreased diffusion capacity and isolation is a manifestation of asbestos pleural disease. And it's in

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the literature and it's been written up that way in the literature. So, all you're doing is producing a smoke screen here.

Q. Well, this is actually not a smoke screen, but rather an ATS --

MR. HEBERLING: Objection. Argumentative.

Q. (BY MR. STANSBURY:) Dr. Whitehouse, is this not --

MR. HEBERLING: Just ask him the question.

Q. (BY MR. STANSBURY:) Is this not an ATS/ERS statement on lung function testing?

A. You know, you could probably quote and find anything you want to out of these studies.

I really am an expert in pulmonary function testing. Starting in 1965 when I was in the Air Force and set up my own diffusion laboratory. I really understand this stuff. And I understand how to do it right. And I understand -- I understand what it means under these circumstances.

You can find whatever you want to, quotes in here.

You haven't told me what kind of spirometers they are using. Are they using computerized stuff, body

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boxes? Are they using nitrogen? What are they using for the studies? None of that is mentioned in here.

Q. My question was, is the ATS/ERS statement a smoke screen?

A. I didn't say it was a smoke screen. This is European, by the way.

Q. ATS/ERS, correct?

A. Yes. ATS/ERS.

Q. That's the American Thoracic Society?

A. Done with the European Respiratory Society.

Q. Oh, it is a joint ATS/ERS statement, correct?

A. Yeah. I assume so.

Q. Okay. That's not a smoke screen. That's an authoritative document, correct?

A. You know, I haven't read there enough to even say very much about it. I know I'm on very solid ground concerning pulmonary function testing. I know I'm on solid ground about it.

Q. Could we move back to 2009_08400, because I think we're going to clarify an earlier point now.

A. 08400?

Q. Yes, sir.

(Pause in the proceedings).

A. All right.

Q. The table in the bottom left corner, and it

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says, "percent predicted," "percent predicted," do you see that, sir?

A. Yes.

Q. And then if you go back to 2009_08404 --

A. What are you referring to here? Severity classification?

Q. Well, I am answering your question about what the measurements were earlier. I think the answer is that it is percent predicted. Because as we see the variables that they are using here are percent predicted. And if you look --

A. No. They are using percent FEV1 over -- Oh. I guest it is FEV1, percent predicted.

Q. That's my point. If you go back to table 12, it mentions in the text, the variables are the same as in tables 6 and 8.

A. You know, those numbers don't even make sense. That doesn't happen in our lab in Libby. And I don't think it's ever happened in any lab I've ever been involved with.

Q. I just wanted to clarify that table 12 does in fact refer to percent predicted, and in order for it to be considered significant for an FVC, according to the ATS/ERS statement, it must be greater than 15 percent per year, and for DLCO, greater than 10 percent, that's my

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point. Is that correct, sir?
A. It still do not know. It doesn't say.
Q. That is what the document says, but you don't agree with it, correct?
A. No. It doesn't say. Because I don't know what you're talking -- I don't know what the percentage is. Percentage of what? Absolute number of the FEV1? FEV1 percentage? FEV1, FVC predicted? Or FEV1 -- FVC over FEV1 percentage? It is not real clear.
Q. But going back to the page we were just on, we were looking at the DLCO issue.
A. The other thing is, they were talking about six units, and the Europeans do some things differently with DLCO than we do in this country, and I don't know what six units are. It should be identified if it's milliliters per minute per millimeter of mercury, which it is not identified as such. None of it's identified.
Q. So, as you stated earlier, you didn't necessarily agree with the statement on 2009_08405 regarding what low DLCO in connection with normal FVC and lung volumes mean, correct? You did not agree with that statement?
A. Oh, I don't disagree with it. It's just that it's pretty small. I mean, it's such a narrow amount of diseases, because there are so many diseases that cause

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this --
Q. Well, ILD, that means --
A. -- that have pulmonary function otherwise.
Q. Well, ILD is interstitial lung disease, right?
A. That's correct.
Q. And there are numerous types of interstitial lung disease, correct?
A. 150 or so, that's right.
Q. Although that's just a sentence, that's well over a hundred potential conditions in which you could see normal FVC, normal TLC, and a decrement in DLCO. But you do not see pleural abnormalities listed here, correct?
A. No, they do not, but they are in many other articles. You're just sort of cherry picking things that you can use to give me problems with this.
Q. Okay.
A. Suggest anaemia, requires very severe anaemia. I would disagree with the DLCO being decreased in early emphysema. In early emphysema, the FEV1/FVC ratio is decreased long before the DLCO goes down.
Q. So, is it fair to say that in formulating the opinions that you will offer at the confirmation hearing, particularly with respect to DLCO and whether pleural

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disease causes DLCO, that you did not take into account the statements in this ATS statement, this ATS/ERS statement regarding lung function?
A. No. Do you want me to take into account every statement that you've come up relative to this?
This is something that I'm not intimately familiar with. So, you can read a statement out of that and I'm supposed to agree or disagree with it, when I've got another statement that may be contrary with that. And that's basically what you're doing here.
Q. Well, let's continue with the rest of this paragraph.
A. And, you know, I'm tired, and I don't feel very well, and I'm going to end this deposition now. Okay.
Q. Dr. Whitehouse, we have not gotten through all of the material. I still have more time.
A. I don't care whether you have or not. You are going to have another chance, another crack at me. I'm done. Okay?
Q. Dr. Whitehouse --
MR. HEBERLING: I'm sorry, Brian --
Q. (BY MR. STANSBURY:) -- let's take a break. Are you walking out of this deposition?
A. I'm walking out.

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MR. HEBERLING: He's already gone beyond probably what he should have. Now, he's not been well.
MR. STANSBURY: This is not what we agreed to.
MR. HEBERLING: You can't agree on what his condition's going to be at the time of deposition.
MR. STANSBURY: We will depose you again.
MR. HEBERLING: Oh, yes. You may do that.
THE WITNESS: You'll get your other crack at me. But we're done for today. That's all there is to it.
MR. HEBERLING: When you're 71 years old, maybe you will understand this. I mean, you've been at him since 8:30 this morning.
THE VIDEOGRAPHER: Are we going --
MR. STANSBURY: Stay on the record.
MR. SCHIAVONI: John, I don't need to go on. I will just reserve my rights. Is that acceptable?
MR. HEBERLING: Certainly you may reserve your rights. You'll get another chance. But, you know, I'll bet we've gone farther than we should have gone already.
MR. STANSBURY: And what is the time, sir?

THE VIDEOGRAPHER: The time is --
MR. HEBERLING: Two o'clock.
MR. STANSBURY: No, no, the time of the deposition.
THE VIDEOGRAPHER: Oh. The total time.
THE WITNESS: Six hours.
MR. STANSBURY: No, it is not.
THE WITNESS: Well, five hours. Excuse me. We had a half an hour for lunch.
(Pause in the proceedings).
THE VIDEOGRAPHER: It is four hours 24 minutes.
MR. HEBERLING: Okay. Brian, off the record. Do you really need a copy of that? You've got one. I mean, there's nothing, I will represent to you, that that is the thing that -- the same thing that we delivered to everybody in December.
MR. STANSBURY: You didn't deliver it to Tanc. We will copy it. Tanc will get a copy. And then we will send the original back to you.
MR. SCHIAVONI: Is that all right?
MR. HEBERLING: Sure. I mean, he's got several others. I've got others.
Doctor, this is formal proceeding, and that's the way it's going to be.

THE WITNESS: All right. Bye.
MR. HEBERLING: Okay. We'll get it back to you.
MR. SCHIAVONI: Thank you, Doctor.
MR. STANSBURY: Do we have the time clear on the record?
THE VIDEOGRAPHER: Yes.
MR. STANSBURY: Okay. We are off the record.
THE VIDEOGRAPHER: This ends the deposition of Dr. Alan C. Whitehouse. The date is March 19, 2009. The time is approximately 1:59. There is a total of three tapes. The case is in regarding W.R. Grace & Company, et al. The tapes will reside with Greg Glover, videographer at Bridges Reporting and Legal Video.
Thank you. We are off the record.

(2:00 p.m.)

* * *

STATE OF WASHINGTON)
) ss.
County of Spokane)

I, William J. Bridges, do hereby certify that at the time and place heretofore mentioned in the caption of the foregoing matter, I was a Certified Shorthand Reporter and Notary Public for Washington; that at said time and place I reported in stenotype all testimony adduced and proceedings had in the foregoing matter; that thereafter my notes were reduced to typewriting and that the foregoing transcript consisting of 271 typewritten pages is a true and correct transcript of all such testimony adduced and proceedings had and of the whole thereof.

I further certify that I am herewith securely sealing the said original deposition transcript and promptly delivering the same to Attorney Brian T. Stansbury.

Witness my hand at Spokane, Washington, on this _____ day of March, 2009.

_____
William J. Bridges
CSR NO. 2421
Certified Shorthand Reporter
Notary Public for Washington
My commission expires: 11-1-11

CERTIFICATE OF WITNESS

STATE OF WASHINGTON)
)
COUNTY OF SPOKANE)

I, ALAN WHITEHOUSE, declare under penalty of perjury under the laws of the State of Washington, that I am the witness named in the foregoing deposition and that I have read the questions and answers thereon as contained in the foregoing deposition, consisting of pages 12 through 271; that the answers are true and correct as given by me at the time of taking the deposition, except as indicated on the correction sheet.

_____
ALAN WHITEHOUSE

Executed on the _____ day of _____, 2009, at _____, _____.
(City) (State)

In Re: W.R. GRACE & CO., et al
3/19/09 - WJB

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